Meeting and treating cultural difference in primary care: a qualitative interview study

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**Background.** Primary care doctors see patients from diverse cultural backgrounds and communication plays an important role in diagnosis and treatment. Communication problems can arise when patient and doctor do not share the same cultural background.

**Objective.** The aim of this study was to examine how consultations with immigrant patients are understood by GPs and how GPs manage these consultations.

**Methods.** Semi-structured interviews with GPs about their experiences with immigrant patients were recorded on audio-tape, transcribed and analysed using a qualitative thematic analysis methodology. A constructivist approach was taken to analysis and interpretation.

**Results.** Culture is not in focus when GPs meet immigrant patients. The consultation is seen as a meeting between individuals, where cultural difference is just one of many individual factors that influence how well doctor and patient understand each other. However, when mutual understanding is poor and the consultation not successful, cultural differences are central. The GPs try to conduct their consultations with immigrant patients in the same way that they conduct all their consultations. There is no specific focus on culture, instead, GPs tend to avoid addressing even pronounced cultural differences.

**Conclusion.** This study indicates that cultural difference is not treated in GPs consultation with immigrant patients. Learning about cultural difference’s effect on mutual understanding between doctor and patient could improve GPs cross-cultural communication. Increased awareness of the culture the doctor brings to the consultation could facilitate management of cross-cultural consultations.

**Keywords.** Communication barriers, communication skills, cultural diversity, GPs, physician–patient relations.

**Introduction**

Immigrant status often means having a cultural identification that differs from the domestic ethnic majority. Culture can be defined as a system of meaning that a group of people share. This system is adaptive and can be taught and reproduced. People tend to experience health and disease from the perspective of their own culture, and create expectations of health care based on these experiences. Communication problems that can lead to inadequate care arise when the patient’s culture and the doctor’s culture engender different understandings of health care, the body, disease and health.

The pattern of immigration to Sweden, as in many European countries, has changed during the past 30 years. The immigrant population is growing, and now 11.8% of the Swedish population was born outside of Sweden. Sweden’s immigrant population is far from homogenous: immigrants to Sweden were born in at least 114 countries on six continents.

The problems that arise in patient–doctor communication when the patient and the doctor do not share the same culture are apparent in primary care. Primary care doctors see many patients with immigrant background and communication plays an important part in diagnosis and treatment. Previous studies investigating the role of the immigrant patient in primary care have focused mainly on how the immigrant patient differs from the ethnic majority patient. If the doctor is studied, research tends to focus on doctors' specific cultural knowledge or experience of working with specific immigrant groups. However, doctors meet patients...
from many different cultural groups, and experience of
cultural difference as a general phenomena is daily for
many doctors in Europe today. Because focus has been
on the patient side of the doctor–patient relationship,
or limited to specific cultural knowledge or experience,
the problems of cross-cultural communication for
primary care doctors have not been well examined.

The aim of this study was to examine how consul-
tations with immigrant patients are understood by
GPs and how GPs manage these consultations.

Methods

Selection of informants
Participants for the study were chosen from a complete
list of all publicly employed GPs in the Scania province,
listed by primary care centre. We divided this list into
centres in an urban setting and centres in a suburban/
rural setting. Within the groups we made a distinction
between sexes. We did a random iteration to produce a
selection of 40 GPs. These received letters inviting
participation in the study during summer 2003. Further
contact was made by email and telephone. Six GPs
could not participate because of time constraints. One
GP was no longer working. Thirteen GPs from our
initial contact group did not reply to the invitation.

Twenty GPs agreed to be interviewed, ten women
and ten men. Of both the men and the women, half
worked in an urban setting and half in a suburban/rural
setting. The GPs were all finished with their specialist
training and had practiced for 5 to 20 years. Eight of the
GPs practiced in catchment areas where the immigrant
population was 38%, high above the national average of
11.8%. Six of the GPs practiced in catchment areas
where the immigrant population was near or identical
with the national average of 11.8%. Six of the GPs
practiced in catchment areas where the immigrant
population was below the national average of 11.8%.
Two of the informants, one woman and one man, were
not ethnically Swedish, speak Swedish fluently but as a
second language, and regard themselves as ‘bi-cultural’.

Interviews
All interviews were conducted by CW during summer
2003. Interviews were held at the individual GP’s office
and took between 25 and 45 minutes.

The interviews were done using a broad topic guide.
Discussion covered the meaning of ‘culture’ for the
informant, the role of culture in the informant’s work,
the experience of meeting patients with other cultural
backgrounds, examples from work experience of
patients with other cultural backgrounds, and problems
in communication. All interviews were recorded and
transcribed verbatim. Two of the interview recordings
were of so poor sound quality that transcription was not
possible; these were recorded as field notes instead.

Analysis

Our theoretical approach in this study was construct-
ivist. In this approach, theory or meaning is understood
as generated and co-created in researchers’ interaction
with the data.13 Theory is not ‘discovered’ in the data,
either is theory applied to the data. Data and theory
are not separate entities; instead, “data are always
products of prior interpretative and conceptual
decisions”.13 Results drawn from studies done from a
constructivist approach are intended to be relevant in
particular to the setting under study and to the research
question.

The methodology used in this study was thematic
analysis based on de- and re-contextualisation of data
by coding.14 15 In this process, we used the ‘hermen-
eutic editing approach’ to analysis as described by
Crabtree and Miller.15 Transcripts were read for an
overview of the body of material. The interview texts
were then coded line for line by open coding and these
codes were condensed into categories. Data collection,
coding and analysis were done concurrently. All
authors coded the interview material separately and
analysis was done in the process of comparing and
contrasting the results of this coding. We generated
theoretical memos in the form of text, charts and
figures. These memos were interpretative, giving a
conceptual framework to the codes. The memos were
sorted and written up in the final stage of the analysis.
In this article we use representative quotations from
our interview data to illustrate our analysis.

Results

Understanding the consultation
For the GPs in this study, the goal of every consultation
was to reach a mutual understanding with the patient.
The patient–doctor interview was seen as a meeting
between two individuals. The individual was in focus for
these GPs, and cultural differences were much less
important than individual differences:

“...The differences between individuals are so great
within the different cultures, and you can’t
translate one individual’s behaviour to another
individual.” (GP18)

Conflicts or problems in the consultation between
doctor and patient were based on individual differ-
ences, not cultural differences:

“I mean, patients are individuals, and if you get to
know them you can think this one is the plague
and the other one is nice, and that’s the same for
Swedes and for foreigners.” (GP16)
The GPs reported experiencing different levels of mutual understanding between doctor and patient in the consultation. Hinders to mutual understanding could be discrepancy between what the two parties expected from the meeting, differences in understanding the problem, or differences in ways of communicating about the problem. In the best case scenario, doctor and patient were in almost perfect agreement, while in the worst case scenario doctors felt they barely communicated with their patients. The level of mutual understanding between doctor and patient was directly affected by differences between the two individuals involved in the consultation. Differences between individuals could be culturally based, but they could also be differences in education level, gender, age, social class, or having urban or rural upbringing.

“T’m thinking of another patient I had at my first practice, a young girl, a Swedish girl . . . she had piercings, she had probably 20 different rings all over. And it was hard to communicate. That is another culture, I mean, a youth culture that is strange for me, that I don’t understand.” (GP1)

“Out here in this very Swedish, very Skanish old farming culture it is easy for me as Swedish born to understand, to know, my grandparents are from the country.” (GP13)

“There is a huge difference within Sweden, between people who have different social backgrounds, I mean a single parent, 24 years old, with a little child or a couple in their 40s with a child . . . someone with another professional background sees things in a different way.” (GP18)

In particular, educational level affected mutual understanding. The following sentiment was expressed by many of the GPs:

“It is less of a problem for example to have patients who come from Iran or Iraq or Afghanistan who are well educated—even from Somalia—who have gone to university and are well educated. They obviously sometimes have the same understanding I have about the body and disease.” (GP3)

Poor mutual understanding leads to a difficult consultation. When communication is difficult, the doctor describes feelings of having compromised the ideal professional role and possibly the patient’s health.

“You can either do what you do when you are rushed and say ‘no’, or else you go along with what they want and do the X-ray you don’t think is indicated, or tests, or write a prescription you don’t think is needed, or you say ‘no’ and the patient leaves there unhappy and misunderstood. Or I can spend time trying to understand what they think and feel, and try to explain what I know based on my knowledge base, and explain why I won’t do as they want . . . But I have very little practical possibility to do that in my work, unfortunately. So those patients get much worse care.” (GP3)

Cultural difference was seen as only one of many factors affecting mutual understanding. However, when the GPs discussed instances of ‘worst case scenario’ consultations where they felt they barely communicated with their patients, cultural difference played a primary role. Many GPs took up examples of consultations they had found particularly difficult, and all of these were marked by being with a patient who had a culture that the GP found very ‘foreign’ and different from their own belief systems:

“I often feel a foreignness that is very, I have a hard time—I find women who live in a ‘veil culture’ especially very difficult. Sometimes you can kind of make your way forward and make contact, but mostly I feel a sorrow, and a rage, when I think about how they are closed in . . . I cannot help them! I do not really understand how they feel. And then I don’t think I am good as a doctor, because I feel this rage, and this sorrow, and that doesn’t help them at all.” (GP1)

These culturally charged consultations were difficult, emotional, and led to a feeling of failure. In these worst case scenarios, the GPs felt they had no way of solving the problem of failed communication, and therefore could not be a good doctor to their patients.

“Sometimes you just don’t understand each other. However much you try . . . As a doctor I feel a failure then. Because I can’t do my job as I would like . . . But I haven’t seen in those consultations that there was anything which could have helped the situation.” (GP7)

Managing the consultation

The GPs emphasized that there was no difference in how they approach consultations with immigrants compared to consultations with Swedish patients. The cultural background of the patient did not make a difference:

“Since the patient is always in a powerless position, it is my responsibility to meet every one of them with respect . . . You regard [the immigrant patient] just the same as any other patient.” (GP10)

The goal of all consultations was a high degree of mutual understanding. The GPs described three different types of strategies to increase mutual understanding in all their consultations.

First, as indicated above, GPs focused on the individual in the consultation. A ‘patient-centred’ consultation method was the golden standard for finding individual solutions for every patient. With
this method the doctor makes room for the patient’s world view in the consultation by asking patients about their expectations, experiences and beliefs. Then, the doctor responds to the particular background the patient brings to the consultation.

“I try to understand the patient, understand their explanations. I ask ‘What do you think this problem comes from?’ ‘How could this happen?’ ‘What can you do to make it better?’” (GP12)

The GPs described trying to find common ground with each individual from which to build a relationship.

“You have to make people understand what you mean, so you search—is there something we have in common, that we can agree on, so that we can understand each other?” (GP9)

Second, the GPs expressed an attitude of western humanism: that all human beings are equal and share the same existential ground.

“There is so much that all people share, all that human condition, love and death, and children, love for children and care, worry about loneliness and alienation ... these are, this is the foundation for all people ... everyone who comes to the doctor is afraid of something, of death, of disease.” (GP3)

Finally, the GPs actively avoid cultural conflict in the consultation. Many examples they took up were about experience of cultural difference as conflict, but this conflict is not expressed in the consultation situation.

“I mean you keep yourself neutral to all that about their culture—I don’t question it, we don’t discuss it, but you try to take it seriously.” (GP16)

Some GPs said that their work environment did not invite discussion of cultural aspects in consultation.

“I don’t think it gets talked about, because then everyone might think you are a racist. I mean, we talk about things that are difficult, but I don’t think we doctors talk about culture per se.” (GP5)

Cultural differences are part of GPs’ daily experience, but discussing these differences is avoided.

Discussion

For the GPs in this study, culture is not treated when they meet immigrant patients. The consultation is understood as a meeting between individuals, and cultural difference is presented as just one of many individual factors that influence how well doctor and patient understand each other. However, cultural differences play a central role when mutual understanding is poor and the consultation is not successful.

The GPs try to conduct their consultations with immigrant patients in the same way that they conduct all their consultations. GPs focus on the individual and use a western humanist attitude. There is no specific focus on culture. Instead, GPs tend to avoid addressing even pronounced cultural differences.

Other research on cross cultural consultation

Our results complement other studies examining cultural differences in health care from the patient perspective. There are indications that good mutual understanding has a high correlation with good compliance, and that mutual understanding is related to the quality of the patient’s relationship with the GP. Also, our study supports current theoretical discussion about the importance of cross cultural communication in the development of mutual understanding in doctor–patient communication.

There is very little work done in the area of cross cultural communication. The doctor’s side of the cross cultural patient–doctor relationship has not been adequately examined. This omission may reflect an assumption that the doctor’s behaviour and perspective is static and therefore uninteresting. Cultural difference is a sensitive area, and in today’s political climate it may be difficult to raise issues about problems related to cultural background. In addition, research on patient–doctor communication is not prioritised although communication is central to the outcome of a patient visit. This study has shown that doctors can be unwilling to bring culture up to discussion, which reflects the general lack of discussion in the literature about the problems of cross-cultural relationships.

Methodology

Thematic analysis of interview data done from a constructivist approach is an appropriate method for generating explanations of phenomena that are directly relevant for the group at study. This kind of research can answer questions about why social processes work the way they do and can describe and explain experience. However, the conclusions drawn in this type of study are not final; instead, they pose new questions and are always open to reinterpretation.

Investigators can never be completely neutral as we carry our backgrounds, both experiential and theoretical, into every research situation. In this study, AB and MT both currently work as primary care physicians. CW has prior training in anthropology and is herself an immigrant to Sweden. We bring this personal experience to the analysis.

There was a risk for selection bias in this study. The doctors who chose to take part in the study may have done so because of a prior special interest or knowledge in the topic. We hope to have minimized this risk with our choice of sampling method.
Validation of results in qualitative research can be problematic. Methods of assessing validity common to quantitative work are not applicable in inquiry-based investigations. Trustworthiness of results can be improved, as in this study, by use of known methodology and by transparency in methodological and analytical description. Our use of multiple researchers in evaluation and analysis of transcribed material also adds to the trustworthiness of our results.

Conclusions

Doctors described cultural differences that were significant for the consultation, but they described using strategies which focused on communication with the patient as individual and actively tried to minimize the influence of culture on the consultation. These strategies reflect culturally based assumptions placing the individual in focus. Similarly, the Western humanist attitude taken by these doctors reflects culturally formed ideas. These strategies also serve the purpose of removing a possibly uncomfortable focus on cultural difference.

However, cultural backgrounds, both the patient’s and the GP’s, are present in the consultation. We have seen that the patient’s culture is often not addressed. In addition, the doctor does not examine his or her own cultural background in the consultation.

Avoiding cultural difference in this way has at least two effects on the outcome of the consultation. First, doctors do not develop strategies for dealing with specifically cultural differences. When these differences arise, they can affect the consultation negatively if they are not addressed. Second, doctors do not reflect on the cultural background that they bring to the consultation. Their ‘medical culture’ perspective, with focus on the individual, Western humanism, and biomedical grounding influences the consultation but the extent of this influence is left unexamined.

This study indicates that cultural difference is not treated in GP consultations with immigrant patients. Learning about cultural differences and how they affect mutual understanding could improve GPs’ cross-cultural communication. Increased awareness of the culture the doctor brings to the consultation could facilitate management of cross-cultural consultations.

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Declaration

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Conflicts of interest: none

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