ELUCIDATING THE DIMENSIONS OF COMMUNICATION AND THE ROLE OF CULTURE IN AN AUSTRIAN MEDICAL SETTING

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Abstract

This piece of research has been conducted with women immigrants and general practitioners to understand their perceptions and experiences in their medical encounter in the Tyrol, Austria. It aims to explore and understand the communication process between women immigrants and general practitioners and to elucidate to what extent culture plays a role in this process. It also examines the views of both participants involved in a medical consultation. Based on the paradigm of social constructionism and phenomenological concepts, a qualitative approach has been taken where 21 semi-structured interviews have been conducted in English and German. The data generated have been categorised and coded using the Thematic Analysis Process. The results highlight that interactional, structural, temporal, procedural and relational differences influence and at times exacerbate the communication practices, despite endeavours of both groups to establish a smooth and effective interaction. The conceptualised doctor-patient consultation framework illustrates the role of cultural resources in the communication process and the impact of small culture on the internal and external outcome. Finally, all the dimensions that influence the communication process result in patient satisfaction or dissatisfaction impacting patient compliance. The selected women immigrants speak English or German fluently, are well educated and work in qualified professions, the doctors are predominantly located in the provincial capital Innsbruck. Thus, this aspect limits the generalisation of these findings. This first of its kind research in this region involving both doctors and patients as well as the patients constitute a diverse population irrespective of their ethnic or national background. This study gives a holistic picture of the small culture formed in a medical setting and facilitates in understanding the way culture is defined, constructed and negotiated through the medical communication practices. Finally, it serves as a basis to understand a consultation better and for further research in this region.

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1 Chapter One Introduction

1.1 INTRODUCTION TO THE RESEARCH TOPIC

Global migration trends have led to an increase in the number of immigrant patients who generally vary in language, illness-related beliefs and practices and health care expectations that doctors encounter (Street, Cauthen, Buchwald & Wiprud, 1995).

In medical care, communication or talk plays an underlying role. Talk with the doctor involves not only his/her diagnoses and patients' questions but it is often accompanied by other factors such as patients' fear and doctors' unspoken assumptions as well as the non-verbal messages that both send. According to Roter and Hall (1992), talk is considered as the fundamental instrument through which therapeutic goals are achieved.

Although talks aim to achieve positive outcomes of their therapeutic goals such as patient satisfaction, patient compliance and patient empowerment in a medical encounter, the immigrant patients' perceptions of how such an encounter should be, could give rise to cultural challenges. A positive outcome of the therapeutic goals is said to be achieved when there is congruence between the doctors and the immigrant patient in view of the illness, diagnosis and treatment regimen.

Doctors, on the other hand, believe that positive outcomes in therapeutic goals can be achieved when all patients, both immigrants and non-immigrants, are treated in the same way. The perception of a health encounter is based on the assumption that fair treatment is ensured when all patients are treated equally in view of their health. This approach assumes that equity is fairness, a supposition that holds if the values and norms of the doctors and the minority patients involved are similar (Perloff, Bonder, Ray, Ray & Siminoff, 2006). Research work has indicated that disparity in healthcare

prevails in view of immigrant patients although it is not intentional (Burgess, Fu & van Ryn, 2004).

One of the reasons may be that all patients perceive a medical encounter differently based on personal values. Some may perceive it the same and others may perceive it differently although equal treatment is aimed at, it may not result in the same outcome unless values, expectations, experiences and the perceptions of patients as how they view such encounters are taken into consideration.

According to researchers (Perloff, et. al., 2006; Zoppi & Eppstein, 2002), immigrants who are mainly minorities in the population makeup are said to face more negative outcomes such as wrong diagnosis and treatment plan, decreased patient satisfaction and non-compliance with the prescribed treatment plan in a medical encounter. This generally happens when patients fail to express their problems leading to difficulties in diagnosis. Also, asymmetry in doctor and patients' perceptions further increases the incongruence between the two participants in a medical setting.

Patients conceptualise their problems and symptoms differently than their doctors (Sue, 2006). Anthropologist Kleinman (1981) noted that illnesses could be culturally shaped in the sense of how patients perceive, experience, and cope with the disease based on their own (a) sickness explanation, (b) explanations specific to occupied social positions, and (c) systems used to define the illness (Mouzon, 2008). Researchers (Perloff et al., 2006) claim that it is possible that perceived differences, as well as actual dissimilarities in cultural values, reduce congruence between providers and minority patients in illnesses, explanations and treatment regimen.

When referring to Austria, where this piece of research has been conducted, all research carried out so far on primary care setting and intercultural health care interactions focuses on a specific group such as the Turkish or religion-oriented groups, vulnerable populations such as elderly persons, persons living with challenges, children and/or women, in particular with regard to women related issues such as mammography screening etc. Little is known about the experiences of women who belong to minority

groups and their perceptions of intercultural encounters with general practitioners, who are generally their first point of contact in a medical encounter (Peintinger, 2011).

The general practitioners play a very important role in the Austrian health care system. They are the "*gatekeepers*" as they are the first ones to come into contact with patients and provide initial treatment before they refer the patients to specialists or hospitals for further treatment or tests (van den Brink-Muinen, Maaroos & Tähpold, 2008). Thus, this study focuses on the experiences and perceptions of women immigrants and general practitioners in a medical setting to understand the communication process and the cultural aspects that may impact the communication in the medical interaction.

1.2 BACKGROUND AND RATIONALE OF THE STUDY

The data presented by the United Nations indicate that the number of international migrants globally constitutes 244 million people, i.e. 3.3% of the world's population. This trend of movement is giving rise to ethnically, culturally and linguistically diverse populations residing in many parts of the world (IOM, 2018).

Coming to Austria, according to the latest national statistics presented by Statistik Austria (2018), the number of immigrants has increased from 1,426,400 in 2008 to 2,022,200 in 2018. In percentage, this shows an increase from 17.4% to 23.3% over the last 10 years. Across the nine states of Austria, the state of the Tirol stands fourth with 21% immigrants, where Vienna, the capital city, tops the list with 45.3% followed by Vorarlberg and Salzburg with 26.2% and 23.1% respectively. The population in the Tirol is composed as follows:

Nationality	Number	Percentage
Austrian	634,695	84.5
Foreigners	116,445	15.5
Total	751,140	100
Foreigners Subdivision		
From EU-27	72,820	62.5
From remaining countries	43,626	37.5

Table 1: Statistics of Immigrants in the Tirol

(https://www.tirol.gv.at/statistik-budget/statistik/wohnbevoelkerung/)

The city of Innsbruck, the provincial capital of the Tirol houses a total of 132,493 inhabitants. 98,336 are Austrians; 8,503 are German nationals; followed by 10,597 from the rest of the EU; 5,185 originate from the Former Yugoslavia; 2,915 from Turkey, and 8,206 come from the rest of the world.

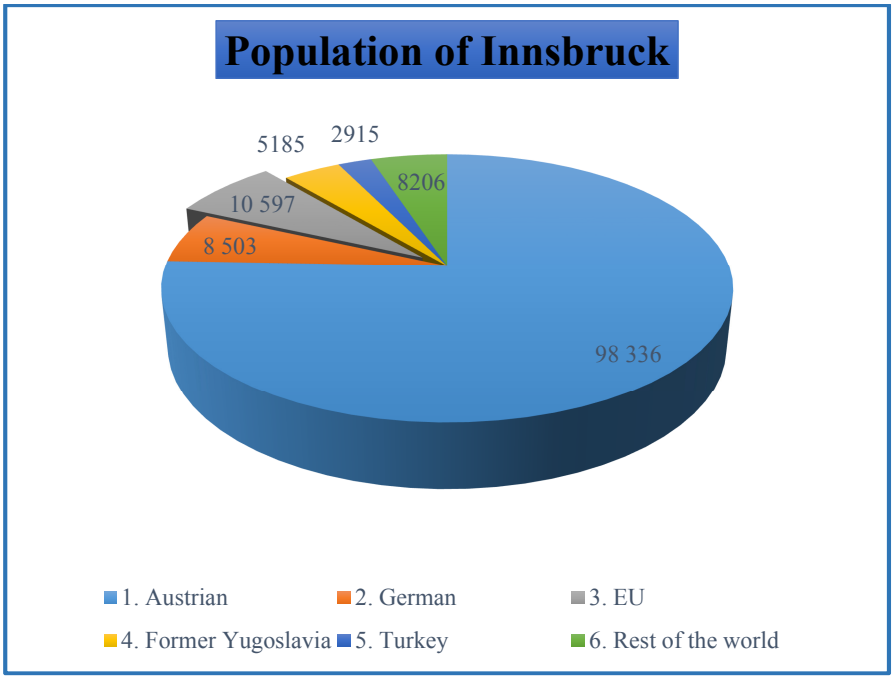


Figure 1: Population of Innsbruck

(https://www.tirol.gv.at/statistik-budget/statistik/wohnbevoelkerung/)

Immigration to a new country in general can be a stressful experience (Aroian, 1990; Bardsley & Storkey, 2000). In most cases it is marked by major disruptions as the immigrant finds him-/herself in a new unfamiliar context due to the cultural, economic and often social change, language problems and conflicts, isolation from one's familiar social networks when living in a new society. All these factors may create stressful and overwhelming experiences (Aroian, 1990; Kuo & Tsai, 1986).

In the case of women immigrants, the situation maybe even worse. In most cases, they enter into the country as "*dependent persons*." They have generally immigrated due to relationships or have followed their spouses or have been displaced due to war, as in the case of Former Yugoslavia. The term "*women immigrants*" refers to women who choose to depart from their homeland legally to establish permanent residence in another country - Austria.

Budman, Lipson and Meleis (1992) asserted that women immigrants should be considered a population that is at high risk for physical and mental distress, which emerges from lack of orientation, from being de-rooted, feeling of loss, identity crisis, etc. Furthermore, those women predominantly show a lack of knowledge in health, health illiteracy, lack of information, poor access to information and above all cultural, linguistic and institutional barriers undermine their situation even further (Baldaszti, 2006).

When it comes to health, Austria ranks among the top 10 countries in the world as regards its health spending which is about 10.3% of its GDP. The health expenditure includes personal health care (curative, rehabilitative, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration (OECD Statistics, 2017). Austria's health expenditures are higher than in most EU countries. About EUR 3,800 was spent on health per capita which is approximately EUR 1,000 more than the EU average (OECD Statistics, 2017). Austria aims at the provision of good health care to all its inhabitants. In 2017, Austria had 5.1 practicing doctors providing direct care to patients per 1000 population (OECD Statistics, 2017).

Consultation in Austria, on the other hand, indicates 6.6 per capita in 2016, which is quite high when compared to other countries. This indicator presents data on the number of consultations patients have with doctors in a given year. Consultations with doctors can take place in doctors' practices, in hospital outpatient departments or in some cases, in patients' own homes. Consultations with doctors refer to the number of contacts with both generalists and specialists (OECD Statistics, 2017).

Interactions in medical settings are becoming more and more intercultural and this may impact and pose various challenges to a health care system. According to Samovar and Porter (2001), immigrants speak different languages for one and also bring along a baggage of culturally different values, beliefs, and customs that impact the way they individuals communicate and relate to.

Furthermore, as mentioned in section 1.1, Kleinman (1981) as well as Helman (2007), posited doctor's and patient's use of explanatory models of health and illness and worldviews that shape doctors' and patients' health perspectives. Researchers (Street, Krupat, Bell, Kravitz & Haidet, 2003) considered a person's worldview of health as having a pre-dispositional influence on one's communication in a medical encounter as this worldview represents the person's beliefs, understanding of health and illness as well as understanding and approach to treatment.

Denley, Rao and Stewart (2003) argue that when differences between physician and patient beliefs and values are unexplored, miscommunication and ineffective medical care may follow. For example, cultural differences in health beliefs may make it particularly difficult for doctors and patients to reach a congruence on decisions about health care issues. Moreover, cultural differences affect individuals' health behaviors and practices as well as strongly impact their decisions on adherence or non-adherence to treatment protocols (Betancourt, Green, Carrillo & Park, 2005).

Besides, several factors such as socioeconomic status, ethnicity, education, gender, sexual orientation, and age differences (Pecchioni & Nussbaum, 2000) also affect and enhance the diversity among the inhabitants. Moreover, all these factors

determine and shape individuals' "*cultural attitudes toward health, health care, and illness*" (Spector & Spector, 2000, p.75). Whaley (2000) stated that all these factors (ethnicity, socioeconomic level, etc.) are extremely important and must be taken into account as they influence how individuals understand and explain in a medical encounter.

From a communication perspective, Mitchell and Cormack (1998) stressed that doctors should be more sensitive "*to the information needs and desires of patients*" (p.153), who are from different cultures. Witte and Morrison (1995) highlighted that patients from different cultures bring along expectations to the medical encounter, which, in turn, are also rooted in their cultural values, beliefs, and customs that get enacted through communication in the medical encounter but that may or may not be fully in line with the expectations of the patient's physician.

The underlying root of most of the frustrations, misunderstandings and dissatisfaction that emerge within both participants in the medical consultation are the results of cultural differences in communication and relationship styles. These differences in communication need to be exposed and explored within the health care environment as they can affect the outcomes of a medical encounter (Street et al., 2003).

On the other hand, Lustig and Koester (1999), Rao (2002) argue that "*the interaction between a physician and patient is inherently an intercultural encounter even when the two parties perceive they are from the same culture*" (p 210). Physicians' and patients' understanding of health issues and treatment as well as healing, could be fundamentally different, and these understandings could stem from individual personal beliefs and practices, thus, accounting for differences in their communicative practices. Hence, it is vital to explore how both participants perceive this web of interaction to develop an understanding of the experiences made by patients and doctors in a medical consultation process.

1.3 PURPOSE OF THE STUDY

The focus of this piece of research is to garner knowledge on women immigrants' perceptions of their medical encounter with their general practitioners (GP) as well as to gain knowledge on general practitioners' experiences during the medical encounter with women immigrants (WI).

As mentioned in the previous section 1.2, it is known that various factors influence the communication process, so this study primarily aims to investigate:

1) Which dimensions impact the communication process?
2) What role, if any, does culture play in the communication process?
3) Does medical interaction impact women immigrants' illness management?

The objectives of this study are namely:

- To understand the experiences and impressions described by women immigrants as well as general practitioners in medical interactions.
- To understand the reactions expressed by women immigrants and general practitioners to their medical interactions.
- To elucidate women immigrants' and general practitioners' common beliefs, values, attitudes and expectations regarding experiences.
- To understand the influence of common beliefs, values, attitudes and expectations on women immigrants' behaviour.
- To understand the extent to which women immigrants integrate the information provided during the medical interaction.

This study involves women immigrants who have immigrated to Austria and live mainly in the Tyrol as well as general practitioners who have their practices in Innsbruck and its peripheral cities. There are several reasons why this research is limited only to women immigrants.

- First, according to literature women immigrants are often seen as "*dependent persons*," as they relocate with their partners.
- Second, they seem to face a higher risk for physical and mental distress on relocation.
- Third, they may face social isolation and exclusion, hence, may be categorised as a "*vulnerable group.*"
- Fourth, research on women immigrants in Austria has concentrated on certain ethnic groups and not on a broader group of women immigrants.
- Lastly, the researcher being a women immigrant too, who moved to Austria 28 years ago, can identify herself with this group and would like to explore their experiences.

1.4 NATURE OF THE STUDY

This study is qualitative in nature as it allows the researcher to study selected issues in as much detail as possible (Patton, 2002). Qualitative methods are particularly indicated in gaining insights into the issues and give key advantages into the inquiry processes of providing unexpected understandings of the events studied (Hoff & Witt, 2000).

The type of qualitative method appropriate for this study is a phenomenological approach. It is the study of the experienced events from the first-person's point of view (Creswell, 2007). The purpose of this method is to investigate real-life phenomena in-depth involving contextual conditions pertinent to the phenomenon being studied. The operative work in phenomenological research is to describe a phenomenon as accurately as possible (Groenewald, 2004). So, this study is designed to capture the phenomenon of medical interactions expressed and described by women immigrants and the general practitioners in an Austrian medical setting.

The researcher aims to gather extensive data employing in-depth interviews with women immigrants and general practitioners. The interviews containing open-ended questions will be audio-recorded, then transcribed and finally analysed. The open-ended questions will produce descriptive narratives on personal experiences of both participants faced during medical interactions so that the lived, told and retold stories of individuals render understanding and "*experience the experience*" through the individuals' points of views (Clandinin & Connelly, 2000, p.50).

Thus, the qualitative nature of the study is essential as it will assist in obtaining details about phenomena such as perceptions, beliefs, attitudes, expectations and communication abilities that are difficult to extract through other research methods. This would help to elicit in-depth information from the women immigrants and the general practitioners in Austria facilitating a clear picture and understanding of their experiences during a medical interaction.

1.5 SCOPE AND LIMITATIONS OF THE STUDY

In this piece of research women immigrants from various ethnic and national backgrounds and doctors, belonging to the majority group will be included. However, the study is limited to women immigrants living only in the Tyrol, in the city of Innsbruck and its periphery. In addition, only the first-generation immigrants living in the region for less than 10 years will be interviewed.

The 10-year cut-off point is used to define "*recent immigrant*" (Chen, Ng & Wilkins, 1996). According to these researchers, it is quite likely that respondents residing for more than 10 years have acculturated and may be influenced by the local practices. This, of course, does not rule out that respondents could also have acculturated even when they have been living in Austria for less than 10 years.

It should also be mentioned that the face-to-face interviews will be conducted in either German or English. In-depth interviews are planned around a set of questions so an interview guide will be conceptualised for each participant group. Open and honest answering of the questions is assumed from the respondents such that their in-depth narratives will reflect an accurate picture of their experiences and their perceptions, even though there may be some hesitance or reluctance in giving candid responses as those responses will be audio-recorded and documented.

Data analysis will be carried out in English, irrespective of the interview language. This means that the step from data collection to data analysis, in the case of German interviews, will be marked by translation. However, it has to be taken into account that the translation of transcripts incorporates a certain amount of subjectivity. The capacity of the researcher to correctly translate interviewees' statements into English may have an impact on the findings gained. So, to avoid subjectivity as much as possible, intra-reliability will be sought, where help will be taken to proofread all the translations.

This is also one of the main reasons, why the exclusion of women immigrants, who do not speak much German or English is planned. The services of an interpreter will not be utilised as loss of information or misinterpretation could take place during the act of interpretation. Moreover, when information is gathered in German, which will be again translated into English, a further loss of valuable information could occur. Hence, to avoid a double loss of information, subjects with less proficiency in German or English will be excluded.

Another delimitation to the study is that the ethnographic method of observation of a medical encounter has also been excluded as this would, on one hand, involve a lot of bureaucracy and restrictions as regards accessibility to observe medical interactions, on the other hand, it is quite likely that the participants may *"be on guard"* and may be conscious of the presence of the observer during the process of observation. Also, in the process of observation, the researcher may and concentrate just on the overt behavior of his/her participants and not on the intentions behind that behavior, which could also

impact the data. Moreover, as opposed to interviews where the researcher can elicit a lot of information through interview techniques, observations tend to generate fragments of data i.e. segments of behavior and it may be difficult to piece them together to get an overall picture.

1.6 SIGNIFICANCE OF THE STUDY

As mentioned earlier in section 1.2, Austria offers comprehensive and good health care provisions to its inhabitants. To enable significant health equity in view of health care provisions, input and insights of immigrant patients' experiences and perspectives are extremely valuable to facilitate appropriate and positive health care provisions and outcomes.

To my current knowledge, as mentioned earlier in section 1.1, research has been conducted on certain ethnic groups of immigrants. There has been no focus on how women immigrants, irrespective of their ethnicity or nationality, perceive the medical interaction and the influence of the medical interaction on the patient's behaviour. In addition, studies have also not included both patients i.e. women immigrants from diverse backgrounds and general practitioners.

Furthermore, understanding the role of cultural factors may, on one hand, lead to ways to improve women immigrants' access to health care, compliance and satisfaction, on the other hand, it may also help to clarify the disjuncture between the perspectives of patients and general practitioners. This may increase cultural sensitivity and awareness among doctors, which, in turn, may lead to more effective intercultural medical encounters.

Finally, improved trust between women immigrants and their general practitioners will empower women immigrants' participation in health care and better illness management.

1.7 OVERALL ORGANISATION OF THE THESIS

The thesis has been structured in the following manner:

The introduction that deals with the basic underlying problems faced in the intercultural communication process between the general practitioners belonging to the mainstream and women immigrants and the resulting research questions that have emerged through these problems. It also briefly describes the rationale of the study, nature, purpose, scope and limitations, significance and the overall summary of the study.

The subsequent chapter two on literature review focuses on the contextual framework in which the research is set. This section involves the theoretical framework of social constructionism – the aspects of cultural reality approach and small culture in the health care context, the link between culture, health and communication as well as gender communication.

Chapter three outlines the research methodology where the underlying paradigms are explained, methodological aspects considered and the research strategy is described in detail. In addition, aspects of research quality, the limitations and boundaries of this approach are also highlighted. The subsequent chapters four and five describe the procedures of data collection and thematic data analysis conducted.

Then, chapters six and seven deal with reporting of the findings and the discussion of the findings respectively. The discussion chapter seven also connects and applies the findings to the theoretical framework in chapter two.

The conclusion chapter eight answers the three research questions, the evaluative rigour, contributions and limitations as well as suggests future research possibilities based on the analysis. The overall structure of the thesis is illustrated in the following Figure 2:

Figure 2: Overall Thesis Structure

1.8 SUMMARY OF CHAPTER ONE

To sum up, health disparity prevails and is said to be more prevalent when patients belong to a minority group. The disparity in health care leads to negative outcomes such as wrong diagnosis, decreased patient satisfaction and compliance. Disparities emerge due to differences in communication, health beliefs and practices, values, customs, etc., which are said to shape the health problems and symptoms. Thus, this research is designed to explore the dimensions of communication and elucidate the role of culture in the communication process between women immigrants and general practitioners; the impact of these experiences on illness management among women immigrants.

Based on the paradigm of social constructionism, a qualitative approach has been taken to understand this phenomenon, where in-depth interviews have been

conducted in English and German. Despite some limitations this study is unique in its kind through its ethnically diverse participants, insofar intercultural studies in Austrian health care have been performed on specific ethnic groups.

Lastly, it is anticipated that this study will gain significance in the Austrian context owing to the ethnical diversity of one group of participants. Moreover, this study tries to understand medical consultations from the perspectives of the women immigrants as well as from the general practitioners.

2 Chapter Two Literature Review

2.1 INTRODUCTION

This chapter deals with theories in the field of intercultural health communication. It pinpoints the link between culture, health and communication by focusing on three main areas of exploration: **culture and health, health and communication, intercultural health communication**. It discusses the themes that come to fore in these areas as well as deals with concepts in the literature on migrant health and gender communication. Finally, it explains the limitations in the literature and stresses the importance of small culture concept and the cultural reality approach embedded in the overarching theoretical framework of social constructionism.

There is vast literature coming from the field of health communication, which deals with different aspects of culture that affect interactions between doctors and patients particularly when patients come from diverse cultural backgrounds. There are many definitions of culture. According to anthropologists (Berry-Caban & Crespo, 2008) culture is a predominant force in shaping behaviour, values and institutions. It generally refers to the way of life of people or society. Spencer-Oatey and Franklin write that *"there are many different types of social groups, and where members of any group share patterns of regularity in some way [...], they can be regarded as belonging to a cultural group"* (Spencer-Oatey & Franklin, 2009, p40). As per this definition, individuals may belong simultaneously to many cultural groups.

For some scholars from the communication point of view, culture incorporates the aspect of ideas, communication or behaviour of a group of people, which gives them a distinctive identity and which are used to organise their internal sense of cohesion and membership (Scollon & Scollon, 2001). For others, all communication takes place not only within a large cultural context but also within multiple micro-cultural contexts like profession, gender, age, etc. to which individuals also belong and both contexts influence communication (Neuliep, 2012).

In brief, culture is said to influence many aspects of individuals' lives such as beliefs, behaviour, perceptions, language, emotions, religion, rituals, family structure, diet, dress, body image and attitudes to illness, pain and many more. All these have an important influence on health and health care, thus, shaping the way individuals perceive illness and the healing process as well as their expectations brought along in a medical encounter.

In this research, it is not attempted to provide a formal definition of the idea of culture nor to give any rigorous cultural descriptions but to gain a better understanding of how culture is defined and looked at. Reference has been made to only those factors that affect intercultural health communication. Thus, literature has been divided according to the three areas of exploration: **culture and health, health and communication, intercultural health communication.** The first area of exploration culture and health deals with the various health belief models that influence the way individuals explain and understand health /illnesses. The second area of inquiry health and communication covers the different aspects of doctor-patient communication. The third area of exploration involves the intersection between health communication and intercultural communication.

2.2 CULTURE AND HEALTH

2.2.1 Different Health Belief Models

Vast literature from the field of medical anthropology, nursing has emphasised the significant connection and relevance of culture and health. Kleinman, a pioneer researcher determined in his groundbreaking research in 1975, the existence of different health belief models across cultures where he highlights that each culture perceives health and illness differently; has different theories to explain the illness; employs different methods for disease treatment.

Kleinman's (1981) explanatory model (EM) is one of the most famous health belief models constructed. This EM is defined as the notions each individual possesses as regards illness and its respective treatment. This explanatory model is held by both doctors and patients. Patients explain the illness and at times the desired treatment; doctors offer explanations to the illness and present therapy. In general, individuals cast personal and social meaning on illness experiences.

Kleinman (1981) claims that EMs tend to be *"idiosyncratic and changeable"* as it is influenced by personality and cultural factors. They are characterised as fuzzy, have multiple meanings and are partly conscious and partly outside of awareness. It can, thus, be said that EMs are employed by all individuals to explain, organise and manage episodes of illness. They do not occur in isolation, as they are a reflection of individuals explaining how it occurred at that moment, what has happened to them and how it should be dealt with. It is only by examining the specific context in which they occur, that EMs can be fully understood. Since EMs are shaped by context their explanations for the illness can vary depending on when and where they are given, to whom and by whom. For instance, an illness may be expressed by an individual differently to oneself, to family and the doctor.

Helman (2007) following Kleinman's health belief model went a step further to explain that differences existed between the patients' and the doctors' culture. According to Helman, each culture develops different lay theories that explain pain, illness, body functions, abnormality as well as the time when the body needs medical attention. These perceptions of the body shape the way individuals interpret and explain certain symptoms and communicate them to the doctor. Helmann (2007) asserts that both doctors and patients come to the medical setting with assumptions and beliefs about what health and illness are. Researchers (Meuuwesen, Tromp, Schouten & Harmsen, 2007), also support the view that both doctors and patients have their own EMs as they explain episodes of sickness and appropriate treatments.

Generally, health belief systems are divided into three major categories: supernatural, holistic and scientific, each with its own corresponding system of related beliefs (Bakic-Miric & Backi, 2008; Bakic-Miric, Butt, Kennedy, Bakic et al., 2018; Gwyn, 2002; Samovar, Porter, McDaniel & Roy, 2017). The supernatural belief system is predominated by supernatural forces, good and evil sorcery, and God. In this tradition, the ill person is considered a victim of punishment rendered by a supernatural being or power. Healer practitioners, who are said to have supernatural powers, usually carry out the treatment. Additionally, one of the oldest and most widespread superstitions regarding the cause of an illness is the evil eye - a belief that someone can inflict harm by gazing or staring at another person. In such beliefs, jade amulets, black colour on foreheads and so one, are applied to ward off these evil spirits (Samovar et al., 2017).

The holistic belief system suggests that an individual is made up of interdependent parts: physical, mental, emotional, and spiritual. So, if one part does not function well, it affects all of the other parts of that person. At the same time, a holistic belief system is also an approach to life in which the ultimate goal is to achieve maximum well-being of the mind, the body, and the soul.

The scientific belief system focuses on the objective diagnosis, scientific explanation and approach to illness, and other bodily disorders. It relies on procedures such as laboratory tests to verify the presence and diagnosis of disease. As a rule, it disapproves of a patient's use of alternative supernatural or holistic health practices, and only tolerates them if they do not interfere with the scientific treatment plan (Bakic-Miric et al., 2008; Gwyn, 2002; Samovar et al., 2017). Since most doctors are trained in this way, they often tend to ignore the non-visible aspects of culture that may interact with health problems.

Several cross-cultural studies have been carried out comparing the health belief models between doctors and patients coming from starkly different cultural backgrounds. Based on a systematic review (Rocque & Leanza, 2015), the following

Table 2 outlines the various factors affecting ethnic minority patients over a span of 19 years from 1995-2014.

The experiences range from not understanding the patients' values and beliefs to the role and authority of the doctor, language barriers, use of interpreters and many more. With reference to studies of this kind conducted in Austria, research has been mainly carried out on the largest migrant population, who are from Former Yugoslavia and Turkey. In the last few years, there seems to be an increase in the number of people emigrating from South East Asia, so data are being collected as regards child health and reproductive health (Binder-Fritz, 2010).

Study	Country	Aim	Sample	Synthesis of Specific Factors Affecting EMPs
Bowes & Domokos (1995) [32]	UK	Explore South Asian women's experiences and use of health services	20 Pakistani Muslim women	Language barriers are problematic, challenging to find a professional interpreter, feel labelled and treated according to traditional clothing)stereotypes (e.g. relating to traditional clothing
Thom, Campell & Alto (1997) [35]	USA	Identify physician behaviours that foster trust	29 patients (1 FG Hispanics, 1 FG African Americans, 2 FG not reported but inferred as White Americans)	EMPsd report more disrespect and discrimination and more negative experiences (e.g. death due to medical mistakes) than Whites. Whether real or perceived discrimination, it affects their trust in physician.
Rodriguez, Bauer, Flores-Ortiz, Szkupinzki-Quiroga (1998) [36]	USA	Identify provider related factors that may affect patient-provider communication about abuse for immigrant women	14 Hispanic and 14 Asian women (n = 28)	Abused immigrant women's discourse is similar to White patients' discourse with regard to disclosing sensitive info (e.g. need to be asked, need to be empathic).
Ali, Atkin & Neal (2006)	UK	Understand the ways in which White and South Asian patients communicate with white physicians	7 White, 18 South Asian	South Asian patients experience language barrier. South Asians prefer White doctor because less importance is attributed to social hierarchy and authority in the UK. Whites and South Asians have different evaluations of similar experiences (e.g. South Asians don't perceive social talk as pertinent to a consultation). South Asians more critical of care than Whites.
Cant & Taket (2006) [46]	UK	Explore lesbians' and gays' experiences of primary care	18 White, 5 Black and other ethnic minority (n = 23)	Gay or lesbian EMPs feel their ethnic minority identity intersects with their homosexual identity. For some, it is felt as potentially increasing their risk and experience of discrimination.
Towle, Godolphin & Alexander (2006) [48]	Canada	Understand the complexity of physician-patient communication in Aboriginal communities	26 Aboriginal patients	Aboriginals experience strong discrimination and distrust in physicians. Feelings linked to historical context and previous historical trauma. Time constraints seem to afflict Aboriginals even more since concept of time is different for Aboriginals; giving someone time is respectful as it shows the other person that he or she is worthy.

Abdulhadi, Shafaee, Freudenthal, Östenson & Wahlström (2007) [50]	Oman	Explore views of type 2 diabetic patients regarding medical encounter	27 Omani	Social hierarchy and respect for authority seems highly valued and prescribed in Oman and patients do not appreciate that; some even prefer a physician from another culture in order to reduce feelings of inferiority.
Fagerli, Lien & Wandel (2007) [52]	Norway	Explore patients' experiences of medical encounters	15 Pakistani born	Pakistani EMPs in Norway experience language barrier. Seems like acculturation experiences influence communication experiences; moreacculturated patients (e.g. workers, fluent in Norwegian) rate experiences as more positive than less acculturated patients.
Lowe, Griffiths & Sidhu (2007) [54]	UK	Explore attitudes and experiences of South Asian women towards contraceptive service provision	17 Pakistani-born, 2 UK-born but Pakistani origin	Pakistani women experience language barrier, difficulty accessing professional interpreters, obliged to turn to family and friends. They feel uncomfortable discussing certain topics in front of family and friends; therefore, they do not receive the information they need. Preference for female doctors. Problems due to cultural values such as respect for authority and negative consequences of ethnic match (e.g. for religious reasons, some physicians refuse to discuss contraception and women feel powerless in broaching the issue).
Julliard, Vivard, Delgado, Cruz, Kabak & Sabers (2008) [57]	USA	Clarify which conditions reinforce nondisclosure of health information in clinical encounters between Latina patients and their physicians	28 Hispanic women (8 born in US , 20 born in South or Central America)	Language barriers are problematic; difficult to disclose sensitive information when working with untrained interpreters because of privacy issues, women are frustated and embarrassed. Values and belief differences, sexual issues are a big taboo. For Hispanics, ned to maintain harmonious relations, so patgients are fearful to disclose sexually transmitted diseases or abuse because of risk of destroying relations. Acculturation influence; women born outside the US prefer female physicians and need established relationship, trust and warmth, whereas US born patients understand that physicians' role is mainly to heal, therefore, not as much importance is attributed to a warm relationship.
Nguyen, Barg, Armstrong, Holmes & Hornik (2008) [58]	USA	Examine elements of physician-patient cancer communication from the viewpoint of older Vietnamese immigrants	20 Vietnamese immigrants	Cultural belief; if you talk about an illness, it will develop. Physicians do not take belief into consideration when discussing prevention of illness. Language barrier is problematic and patients are not aware that the system needs to provide an interpreter. Patients accept the paternalistic model. Although they feel they do not have enough information to understand tests and procedures, they do not adopt the active patient role since for them it is the physician's role to initiate conversations.
Shelley, Sussman, Williams, Segal & Crabtree (2009) [60]	USA	Compare patients' and physicians' perspectives on communication about complementary and alternative medicine	40 Hispanic, 5 Non-Hispanic White, 48 Native American	EMPs and Whites discourse is similar except that the EMPs´, alternative medicine seems to be more related to their cultural traditions, therefore they do not think the physician would understand or that it concerns the physician.

Peek, Odoms-Young, Quinn, Gorawara-Bhat, Wilson & Chin (2010) [63]	USA	Examine African American patients' perceptions of the influence of race on physician-patient communication	51 African American	African American patients experience discrimination based on physicians' stereotypes (e.g. do not have as much time to talk as White patients, feel as if the physician did not explain because believed that Blacks would not understand). Most patients agree that it is best to consult a Black physician, ethnic match is positive.
Black (2012) [67]	USA	Explore elders' perspective of the influence of their beliefs on health care encounters	60 African American Elders	Black elderly patients say they feel more discriminated on the basis of their old age than on their skin colour, although many had examples of discrimination linked to their skin colour. Patients do not like that physicians do not inquire or know about their health and illness representations and cultural beliefs.
Burton (2012) [68]	Guatemala	Explore the ways in which facework influences physician-patient interactions for Achi patients	24 Achi Aboriginal patients	Aboriginals experience serious discrimination (e.g. being ignored,physically and psychologically abused, and neglected). Physicians do not take into account cultural beliefs and norms when communicating (e.g. speak directly to patient and criticize their habits, for Achi, need to communicate indirectly to remain polite and respectful).
Dahm (2012) [69]	Australia	Explore the relationship between perceived time constraints, jargon use, and patient information-seeking	7 Non-Native English-speakers from Europe and Asia, 10 Native English-speakers (n = 17)	EMPs feel the same about jargon and time constraints as general patient populations, but they do not focus and complain as much about short consultation times because consultations are even shorter in their countries of origin.
Shannon, O'Dougherty & Mehta (2012) [72]	USA	Explores refugees' perspectives regarding communication barriers impeding on communication about war related trauma	37 Liberia, 3 Laos, 3 Asian, 4 Africa, 1 Bosnia, 3 South American (n = 50)	Differences in health representations; EMPs did not perceive war-related symptoms or emotional distress as health-related. Discourse is similar to White patients regarding disclosure of sensitive information; they believe they should defer authority to physician and should not be the one to initiate such conversations.
Weber & Mathews (2012) [73]	USA	Explore patients' perceptions of the quality of care delivered by a foreign international medical graduate physician	4 White, 5 Black, 1 Native American	Majority of patients evaluate experience as positive because of status equalization effect between ethnic minority physician and patients. However they mention language barriers associated to foreign physician's accent.

Claramita, Mubarika, Nugraheni, van Dalen & van der Vleuten (2013) [75]	Indonesia	Examine cultural relevance of Western physician-patient communication style to Indonesian physician-patient interactions from the patients' and physicians' perspective	20 Javanese patients (Indonesian)	Majority of patients in non-western country are not satisfied with paternalistic styles but are less able to defy this style because of predominance of collectivist values to maintain harmonious relationships and respect for authority.
Bayliss, Riste, Fisher, Wearden, Peters, Lovell, & Chew-Graham (2014) [80]	UK	Explore possible reasons why people from Black and ethnic minority groups may be less frequently diagnosed with chronic fatigue syndrome or myalgic encephalitis	6 Pakistani, 2 Indian, 2 Black British, 1 Other White	Language barrier is a problem for patients in expressing their symptoms and in understanding the physician. Some turn to professional interpreters, however, the interpreter does not always understand the patient's dialect. Others bring family members or notes written by a community member. Patients feel physicians have negative stereotypes of their culture (e.g. lazy and complainer) and treat the patients accordingly.
Rose & Harris (2014) [84]	Australia	Explore the experiences of ethnically diverse patients with diabetes in receiving self-management support from GPs	11 Arabic-speaking migrants, 9 English-speaking migrants, 8 Vietnamese-speaking migrants	Patients feel they are not provided with enough culturally tailored advice. Some patients also aim to protect the relationship with their physician, although they dislike the paternalistic style.
Melton, Graff, Holmes,Brown, & Bailey (2014) [86]	USA	Explore the experience of asthma patients in the management of their illness	4 African American	Patients feel discriminated against based on their skin colour and historical tensions between African Americans and White Americans influence the way patients experience the consultation with physicians.
FG: Focus group interviews. EMPs: Ethnic minority patients				

Table 2: Systematic Review of Studies on EMPs' Experiences

EMP=Ethnic Minority Patient

2.3 HEALTH AND COMMUNICATION

As seen in the above Table 2 the development of good communication skills to establish a good relationship with the patient is also stressed. Since the introduction of the classic work on therapeutic communication by Watzlawick, Bavelas and Jackson (1967), it is known that in any interaction a relationship develops between the

participants. A process that takes place automatically and the quality of that relationship has a strong influence on the primary goal of the encounter, which is the exchange of relevant information to facilitate the desired outcome (van Dalen, 2013).

The desired outcome in a medical encounter can be described as primarily to achieve mutual understanding and consequently an optimal exchange of information, which, results in patient satisfaction and patient compliance i.e. patient's adherence to the treatment regimen.

2.3.1 Doctor-Patient Communication

2.3.1.1 Biomedical vs Biopsychosicial Approach

As mentioned earlier in section 2.2.1, the scientific belief system, sometimes called Western biomedical ethnocentrism, strongly prevails in the doctor's world. (Bakic-Miric et al., 2008; Bakic-Miric et al., 2018; Gwyn, 2002; Samovar et al., 2017). The core approach of medicine is to treat illness, alleviate one from pain and suffering and improve human welfare. The scientific approach to illness and treatment is purely based on scientific rationality where all assumptions, hypotheses can be tested and verified under objective, empirical and controlled conditions. Health and sickness phenomena can only become "*real*" when they can be observed and measured objectively under these conditions (Helmann, 2007). Once they are observed and measured i.e. quantified, they become clinical "*facts*" and the clinician aims to discover the logical chain of causal influences that lead to that specific fact. So, it can be said that modern medicine is evidence-based, which mainly focuses on obtaining and quantifying physiochemical information about the patient than on social and emotional factors which are hard to measure.

Fabrega and Silver (as cited in Helman, 2007) point out that the medical perspective assumes that diseases are universal in form, progress, and content and that they recur i.e. they are the same in whatever culture or society they appear i.e. the same cause, clinical picture, treatment, etc. This view, however, does not take into account the

social, cultural, psychological dimensions of ill health nor does it consider the context in which it appears. The context plays a vital role as it determines the meaning of the disease for the individual patients and those around them. Since modern medicine is evidence-based and focuses more on the physical dimensions of illness, factors such as culture and socioeconomic status, personality, religious beliefs are ignored and considered irrelevant in making a diagnosis and prescribing treatment.

Engel (as cited in Helman 2007) sees this approach as further evidence of mind-body dualism a medical mindset, which identifies physical abnormalities while often ignoring the patient as a person. The human being is reduced to a set of physiological parameters. This reductionist approach where doctors only diagnose and treat abnormalities of a small part of the human body is further supported by advanced technology, which aids physicians in making a diagnosis. Although this evidence-based or biomedical approach is the most widely defined and prevalent approach to medicine, it is partly resisted and opposed by some scholars as they prefer and suggest the inclusion of the biopsychosocial approach.

The biopsychosocial model introduced by Georg Engel advocates the inclusion of the psychological and social dimensions. Roter (2000) also mentions the biopsychosocial approach where doctors consider physical evidence but may also take into account the spiritual, emotional, cultural and psychological components that strongly influence a patient's state of wellbeing. According to Beck (2001) this is a holistic approach to diagnosis and treatment where the physician tries to understand the patient as a whole. This approach is unfortunately not widely practiced in today's consultation due to scepticism as they are not evidence-based.

From the patients' perspectives, it is very difficult for them to obtain or to discuss psychosocial information regarding their condition (e.g. emotions and impact of illness on their lives) as the biomedical culture orients conversations towards physical symptoms and biological aspects of one's condition (Hughes, 2013; Moffat, Cleland, van der Molen & Price, 2006). Although some patients recall attempting to address

psychosocial issues and being dismissed, most patients report waiting for the physician to broach psychosocial aspects and report not feeling confident in raising such topics. Consequently, patients did not have the opportunity to tell the doctor about pertinent psychosocial information related to their illness (Kokanovic & Manderson, 2007; Yorkston, Johnson, Boesflug, Skala & Amtmann, 2010). This makes it difficult for the doctor to have a global understanding of the patient's psychosocial context and to tailor the treatment plan to the patient's context.

2.3.1.2 Doctors' Communication Style

Researchers (Freeman & Sweeney, 2001) revealed in their study conducted in the UK that patients valued a personal relationship when they were experiencing a psychological or significant health problem more than when they were just seeking assistance for a minor problem. Researchers (Barry, Stevenson, Britten, Barker & Bradley, 2001) interviewed doctors and patients after their consultation and discovered the existence of three main communication patterns:

1) When both doctors and patients use the language of medicine i.e. biomedical approach.
2) When both engage in more lifeworld talk.
3) When both engage in a different style and the doctor blocks or ignores the lifeworld talk brought in by the patient.

These scholars inferred from their research that the last communication pattern led to frustration among the patients and the desired therapeutic outcomes were as regards the other two patterns poorer. They posited that physicians should be able to adapt to and switch their communication strategies according to what is needed by the patient i.e. more biomedical or more biopsychosocial. This flexibility and adaptation will lead to better outcomes. However, it has been observed that in many consultations the doctors use a biomedical style of communication, where doctors focus on their own agenda with

biomedical-structured questions, thereby, leaving less room for patients to give their input (Patternote, Scheele, Seeleman, Bank, Scherpbier & van Dulmen, 2016).

Research on prospective medical students (Rocque et al, 2015) shows that medical socialisation neutralises sociocultural differences among medical students. Consequently, medical students tend to overlook and neglect sociocultural influences in medical encounters. These doctors did not address the patient's cultural background but tried to get insight into the patient's perspective by figuring out what s/he thought to be the cause of the complaint (e.g. pain). Also, many doctors did not check the foreknowledge of the patient about the diagnosis and treatment policy. They also had difficulties shifting from their biomedical communication style to the context and expectations of the patient (Rocque et al, 2015)

According to researchers, (Aitini, Martignoni & Labianca, 2014) communication has content and a relationship aspect. The content is WHAT is verbally said and the relationship aspect is HOW it is said nonverbally. Both the sender and the receiver of information interpret their behaviour during communication merely as a reaction to the other's behaviour. These concepts are very important, as, in addition to identifying patient's illness, the doctor should also focus on the social, ethical and spiritual aspects and on what can only be defined as "*the biography*" of the patient.

Health communication studies have strongly emphasised from the early 70s (Sharf 1993) on communication behaviours and interpersonal relationships that emerge among interactants in the context of health-related issues. There is substantial research carried out from the perspective of doctors (du Pré, 2001; Roter, 2000; Vanderford, Stein, Sheeler & Skochelak 2001) as well as from the perspective of patients (Barshers, Haas & Neidig, 1999; Cameron, Silk, Afifi & Theodori, 2000; Rao, 2002) in view of doctor-patient communication.

2.3.1.3 Doctors' Relationship Styles

Du Pré (2001) studied the biopsychosocial talk of a doctor when dealing with patients in a medical consultation. Biopsychosocial talk is said to have a positive outcome such as patient satisfaction and to reduce stress in the doctor. She identified six communication techniques used by doctors to elicit patients' talk beyond biomedical facts. These communication techniques are, namely: self- disclosing, expressing empathy; involving patients in decision-making; talking openly about patients' fears; asking open-ended questions, and listening attentively. She acknowledged the fact that doctors and patients communicate very differently, however, she did not look into the cultural aspect i.e. if it also impacted the situation.

Similarly, researchers (Vanderford et al., 2001) analysed the accounts of 111 experienced clinicians in their encounters with patients. Most of these accounts involve the challenges doctors and patients confront in a medical encounter where beliefs about illness, treatment and the expectations of the medical encounter can conflict. The study provides a deep insight into the doctor-patient relationship, however, it only represents the doctors' perspectives, as it would have also been interesting to see the perspectives of the patients i.e. what they confront in their interaction.

Various other research in this field (Emanuel & Emanuel, 1992; Roter, 2000) highlights the usefulness of different models related to doctor-patient interaction. Emanuel and Emanuel (1992) describe four ideal types of physician-patient relationships: paternalistic, informative, interpretive and deliberative. Each of these types explains the role of the doctor in a medical consultation. The paternalistic and the informative can be seen on one end of the continuum, both more focused on biomedical aspects, where in the first one (paternalistic), the doctor is the expert and s/he makes all the decisions for the patients. In the second type, the doctor provides information to the autonomous patient.

On the other end of the continuum, the interpretive and deliberative type can be placed where the interpretive doctor is like a counsellor who gives information to the patient and helps to "*interpret the patient's values for the patient*" (p.2222) but does not make the decisions for the patient. In the last type, the doctor by respecting the patient's values and beliefs helps the patient through their conversation to understand what s/he can do. The doctor may offer suggestions; however, it is the patient, who decides what is best for him/her. The doctor is more like a friend and not an expert or decision-maker.

The researchers feel that this is the ideal type of doctor-patient relationship as it respects and considers patient autonomy along with a care-related attitude of the doctor. Nevertheless, in certain circumstances, the other mentioned types may be more appropriate like in an emergency where patient's consent may be difficult, the paternalistic type of interaction would be most suitable.

In a similar vein, research (Roter, 2000) demonstrates three main types of doctor-patient relationship where each highlight a way of communication, decision making and use of power. The three types are namely: paternalistic, consumerist and relationship-centered. In the paternalistic model, the doctor is said to be the expert, who defines the agenda and goals; determines the treatment; makes the decisions for the patient.

In the consumerist model, the patient is the consumer and the doctor serves as the service provider, provides the patient with a lot of information and the patient, the consumer, then decides on a plan of action. In the relationship-centered model, the doctor and the patient share an egalitarian role where both are equally responsible for shaping their relationship.

In reality, very often the dominance of biomedical culture fosters an asymmetric physician-patient relationship that must be endured by patients. For instance, the paternalistic way, by orienting the conversation towards physical symptoms and discussion on psychosocial aspects related to the condition, given the patients the feeling of being powerless with little control. Some patients even described the negative

experience of feeling like a child because the physician behaved in such a paternalistic manner by deciding on the treatment plan, resorting to complicated jargon, and neglecting the patient's expertise with regard to the illness (Kokanovic et al., 2007; Matthias, Bair, Nyland, Huffman, Stubbs, Damush, et al., 2010; Mercer, Cawston & Bikker, 2007; Vickers, Jolly & Greenfield, 2006).

According to Roter (2000), the relationship-centered model is the ideal form of the doctor-patient relationship, as the physicians tend to focus not only on the biomedical but also on psychosocial aspects, where they take a more holistic approach to the treatment of patients as they are more care-oriented in their consultation. Whereas, the doctors following the paternalistic and consumerist models, focus on the biomedical aspects, that is, on the disease, and are said to be more task-oriented in their consultation. Roter (2000) feels that it is the doctor's responsibility to "*help patients assume an authentic and responsible role in the medical dialogue and decision-making*" (p.8).

Researchers (Emanuel & Emanuel, 1992; Roter, 2000) express their preference for a doctor-patient relationship model where the patient is given appropriate and substantial information to be able to make a decision, whereby the autonomy of the patient as an individual is respected. However, the cultural aspects, which may influence the patients' preferences in terms of the medical approach (biomedical or biopsychosocial) and the type of doctor-patient relationship are not examined in these studies.

Several cross-cultural studies have been conducted on the communication and relational style of the doctors. In a cross-cultural study carried out in the Netherlands the instrumental (biomedical) and affective (biopsychosocial) aspects of communication were assessed. It was found that there were major differences in the affective behaviour dimensions but not in the instrumental dimensions. Doctors had to invest more time in trying to understand the immigrant patient while in the case of Dutch patients there was more involvement and empathy. The differences were discussed in terms of the patient's

ethnic background, cultural views (e.g. practicing a religion) and linguistic barriers (Meeuwesen, Harmsen, Bernsen & Bruijnzeels, 2006).

Cross-cultural studies conducted between the new EU countries (Estonia, Poland, and Romania) and the old West-European EU countries showed that the talk in Romania was more psychosocial as opposed to Poland and Estonia where consultation was mainly biomedical. Furthermore, the verbal contribution of general practitioners in the new EU countries was greater than in the old EU countries. The different communication styles were concluded to be culturally bound but which cultural characteristics are reflected in the communication styles were not determined (van den Brink-Muinen, Maaroos & Tähepold, 2008).

Further cross-cultural research carried out by famous scholars has investigated if dimensions of national culture can predict cross-national differences in medical communication, where Hofstede's dimensions were investigated (Schouten, Meeuwesen & Hamersen, 2008).

Studies in Western settings have shown that open and clear communication between doctors and patients can facilitate optimal delivery of health care (Maguire & Piceathly, 2002). Other studies posit that patients do not necessarily express their lack of understanding or may overestimate what they have understood, whereas physicians may overestimate the clarity of their own talk and rarely check what patients have actually understood (Landmark, Svennevig, Gerwing & Gulbrandsen, 2017).

However, a mutual understanding between the doctors and patients can be enhanced when both actively engage in dialogue and information exchange during consultations (Charles, Whelan & Gafni, 1999; Makoul & Clayman, 2006). This is characterised as a partnership communication style (Claramita, Nugraheni, van Dalen & van der Vleuten, 2013).

2.3.1.4 Patients' Satisfaction during Medical Interactions

The patients' perspectives looked into by scholars predominantly encompass patient satisfaction. They have researched how good communication with the doctors and a patient-centered approach to the relationship result in patient satisfaction (Barshers, Haas & Neidig, 1999; Cameron, Silk, Afifi & Theodori, 2000; Rao, 2003).

Epstein (2007) states that the first impression a patient has of a medical encounter is critical; followed by the level of attentiveness shown by the doctor, next, the context is of importance i.e. who is the patient, the severity of the illness, the support in place for the patient, finally, the perspective of each person involved in the consultation, which tends to differ.

Peters and Epstein (2009) use the term "*shared mind*" that reflects the ideal situation where clinicians and patients have a shared understanding of the patient's health condition; have an accurate understanding of the other's perspective; and are in agreement on the best treatment option. To achieve this outcome, more patient-centered communication is required from both interactants. The providers should consciously:

1) Take the effort to elicit, understand patients' perspective
2) Understand the psychosocial context of patients' health
3) Involve patients in care and decision making to the extent patients desire
4) Provide clear and comprehensible explanations
5) Foster a relationship based on trust and commitment (Epstein & Street, 2007).

Likewise, the patients should also consciously:

1) Be engaged in the consultation and decision-making process where patients ask questions; state preferences; express concerns; convey understandings; offer opinions (Street & Millay, 2001).

Thus, both have to work together to gain common ground; reconcile differences in opinion if necessary; negotiate a common understanding; and agreement on a treatment plan (Epstein & Street, 2007).

According to researchers (Cameron et al., 2000) patients show greater satisfaction when they get the chance to ask questions, actively engage in information seeking during their medical encounters. Moreover, patients were dissatisfied when the doctors did not address their questions properly or when they "*did not understand the information*" (p.11) given by the doctors. Patients also stated that they want the doctor to acknowledge that they already have some knowledge.

They (Cameron et al., 2000) assert, thus, that "*patients no longer see themselves as an inactive participant in a paternalistic relationship because they expect to negotiate their health care with physicians*" (p.17). These scholars state that it is important to understand the differences in goals and expectations that each interactant brings with him/herself to the medical setting to avoid the miscommunication that may take place.

Moreover, adequate communication fosters the development of a satisfactory relationship that allows patients and doctors to engage in proper information exchange; decide on a treatment plan; and ensure adherence to treatment (Rocque et al., 2015; Swenson, Buells, Zettler, White & Ruston, 2004). Nowadays, doctors in Western countries are taught to use a patient-centered communication style (Ball, Dains, Flynn, Solomon & Stewart, 2014; Saha, Beach & Cooper, 2008; Teal & Street, 2009).

In patient-centered communication, the doctor is responsible for the non-medical or interpersonal aspects of the communication (Grol, de Maeseneeer, Whitfield & Mokkink, 1990; Patternotte et al., 2016). The interpersonal aspects of care, for example, trust, respect and empathy are key determinants of patient satisfaction (Saha et al., 2008).

In an intercultural context, patient-centered communication is probably even more important, because the balance in the interpersonal aspects of the communication is harder to find when doctors and patients have different norms and values. Intercultural and patient-centred communication have not been formally integrated together in medical education, although the function of both intercultural and patient-centered communication is to improve healthcare quality in similar ways (Patternote et al., 2016). Nevertheless, communication difficulties persist in medical encounters.

Such difficulties can engender serious consequences. For instance, inadequate communication has been linked to patient dissatisfaction with care, incomprehension of treatment plan, non-adherence to treatment, lower quality of care and of physician-patient relationship, overutilization or underutilization of resources and medical errors (Beck, Daughtridge & Sloane, 2002; Roter & Hall, 2006; Sommer, Macdonald, Bulsara & Lim, 2012; van Wieringen, Hamersen & Bruijnzeels, 2002). Studies also show that during consultations with ethnic minority patients, doctors behave less affectively, more misunderstandings occur, patients report lower satisfaction with care and communication, resulting in poorer adherence to treatment (Rocque et al., 2015; Schouten & Meeuwesen, 2006).

Furthermore, patient satisfaction is said to improve when doctors, as well as patients, enhance their communication skills. Researchers (Evans, Stanley & Burrows, 1992) highlighted the differences in the patients' level of satisfaction when interacting with medical students after those students had received communication training. Patients seemed more satisfied with those students.

Scholars (Cegala, Mc Lure, Marinelli & Post, 2000), on the other hand, trained patients in communication skills. They tested the effectiveness of training patients in information seeking to empower them to become more active in their participation and to obtain better results in their medical interactions. This study showed not only an improvement in the patients' communication with their physicians, but increased patient

satisfaction as they had achieved what they wanted i.e. their goals were accomplished and their expectations were fulfilled in the medical encounter.

Although studies welcome and support the need for doctor-patient communication training; they, however, doubt if generic recommendations in training which emerge from the Western parts of the world, are valid in all circumstances and fit to the aims, patients may have with their visit to the doctor (van Dalen, 2013).

Some researchers have explored which communicative behaviours of doctors are connected to increased patient satisfaction (Wanzer, Booth-Butterfield & Gruber, 2002). Among other behaviours "*empathic communication, listening, and immediacy were particularly important behaviours predicting greater satisfaction*" (p.22). Immediacy communicated by doctors through non-verbal behaviour was said to more receptive to patients' messages and their patients were said to have felt more satisfied. Cultural aspects, however, were not considered.

Furthermore, most research focuses on the impact of verbal communication i.e. what the doctor says, although the non-verbal aspects of communication i.e. how the messages are conveyed are known to be equally relevant for the interaction (Burgoon & Bacue, 2003; Hillen, de Haes, Verdam & Smets, 2018).

2.3.2 Doctor-Patient Interaction

A large number of studies have explored the interaction of doctors and patients (Cegala, Mc Gee & Mc Neils, 1996; Cegala, 1997; Fisher, 1995). Cegala (1997) examined 32 videotaped doctor-patient interviews to determine the topics of talk; information exchange; relational communication. This research deals with the communication skills that doctors enact during medical interviews, the power dynamics, decision-making, compliance gaining strategies, information giving and communication styles with patients.

It provides in-depth information on the topics of communication and relational aspects that get constructed in the doctor-patient interaction. Although the medical interviews were conducted with patients from different ethnic backgrounds, the cultural differences in the communication and relationship styles of doctors and patients were not examined.

Another topic examined in the doctor-patient interaction is the perception of the communication competence of both doctors and patients. Researchers (Cegala et al., 1996), who were pioneers in this field, found that patients perceived themselves as competent communicators when they were able to describe their health problems; answer the questions asked and seek information. Patients also perceived doctors as competent when they provided clear information such that they understood it and when doctors also verified that the patient understood the information. The doctors were said to be relationally competent when they created an atmosphere of trust, support, care and demonstrated empathy.

Likewise, the doctors felt the same about their patients' competence. Furthermore, the doctors felt that patients should stay focused, which is an important aspect when it comes to information exchange. Researchers (Cegala, Gade, Lenzmeier-Broz & McClure, 2002) reported in another study that the doctors felt the patients were competent when the patients were "*well prepared*" (p.13) to ask questions about their diagnosis and treatment. Patients stated that the doctors were communicatively competent when they provided and sought information.

Furthermore, the importance of meaning, messages and transactional perspective is also emphasised upon in communication research. Clark and Delia (1979) say that there are three kind objectives in every communicative transaction:

1. Instrumental – involves completing a task.
2. Identity objectives – managing self-presentation and facilitating the other's identity management.

3. Interpersonal – involves establishing or maintaining a relationship.

Although these three objectives can be carried out simultaneously in an interaction, these researchers discovered that generally instrumental goals receive the greatest attention as opposed to the other two that unfortunately get scant or scarce attention.

Focusing mainly on the patients' perspectives, Gasparik and team (2014) analysed 84 doctor-patient interactions and concluded that medical encounters often lack relevant behavioural elements, gestures, and speech acts, which might help patients feel comfortable during the consultation. However, this research also confirmed that patients are more satisfied when their needs are satisfied. Moreover, this research outlined teachable techniques, which may help patients to derive the most from the doctors. Patients can be taught to define questions in advance; keep focused on the main problems; provide doctors with accurate, relevant information on the disease, side effects of treatments, circumstances when they occurred.

By keeping a track of symptoms and concerns between visits; writing memos before or during the encounter, patients will learn to remember important points. Letting a doctor know about the patient`s dissatisfaction requires assertiveness. All these behavioural elements and speech acts can be educated. Lastly, the patient must also share his/her availability to get involved in a shared decision making regarding the treatment. (Gasparik, Abram, Ceana, Sebesi, Farcas & Gasparik, 2014)

2.3.2.1 Perceptions of the Roles of the Doctors

The perception of the role of the doctors is another theme that emerges from the health communication literature. In various studies, the power distance dimension of Hofstede is discussed and mentioned in view of the role of the doctors. Power distance is considered as one of the barriers that may lead immigrants to be less expressive and passive in a medical consultation (Kale, Finset, Eikeland & Gulbrandsen, 2011) Pronounced differences were found in expectations of low power distance and high-power distance in different cultural groups. To create effective doctor-patient

interactions, the study suggests that doctors would need to know how patients define and expect power distance and that it may take a long time to develop a relationship with patients from some cultures (Gao, Burke, Somkin & Pasick, 2009).

Furthermore, researchers (Walker, Arnold, Miller-Day & Webb, 2001) looked at how doctor-patient relationship get negotiated and constructed through communication during a clinical visit and found in their analysis that five themes characterised the relational communication of doctors and patients, namely: control, role negotiation, health care commitment, trust, time and money. Although this study shows how relationships get co-constructed in a medical setting and is a significant exploration, it has its limitations as this study focuses only on the ethnic majority group and it is questioned by the scholars themselves if these same themes would emerge if culturally diverse patients were observed in the doctor-patient interactions.

Young and Flower (2002) express that most of the misunderstandings between doctors and patients occur due to different expectations, goals, needs, and interpretations during a medical consultation. According to them, those differences make any medical encounter intercultural in nature. They developed a communication model called "*collaborative interpretation*," (p.69) which is said to be capable of narrowing the cultural gap between patients and doctors and converting patients into partners and problem solvers. The model rests on the idea that patients should be encouraged to participate in health care conversations and make their own decisions. Although this model aims at national and ethnic cultural differences; it does not take into account aspects such as power, authority, personality, etc.

2.3.2.2 Perceptions of Gender of Dyads

Various studies (Cora-Bramble & Williams, 2000; Davis, Williams, Branch & Green, 2000; Gabbard-Alley, 2000; Nussbaum, Pecchioni, Grant & Flowell, 2000; Whaley, 2000) have focused on variables like age, gender, ethnicity and education level and how those variables impact doctor-patient communication and patient

understanding of illness. Scholars (Cooper-Patrick, Gallo, Gonales, Vu, Nelson & Ford, 1999) seek the connection of doctor-patient relationship to diversity.

Research carried out on the influence of ethnicity and language within the doctor-patient interaction indicates that patients with poor language proficiency receive poorer quality care, less information and demonstrate poor recall of information. Also, ethnic minority patients seem to express less confidence in being treated equally by physicians (De Maessschalck, Deveugele & Willems, 2011; Gordon, Street, Sharf, Kelly & Souchek, 2006; Johnson, Saha, Arbelaez, Beach & Cooper, 2004).

Research on the gender of the doctor and patients shows that gender also plays a crucial role in the consultation. Female doctors generally seem to appear more partnership-oriented and show more non-verbal and effective verbal behaviours. Doctors independent of their gender seem to give fewer signs of empathy towards male patients and female patients are said to express their concerns more easily (De Maessschalck et al., 2011; Street, Gordon, Ward, Krupat & Kravitz, 2005)

Research conducted in this field (Sandhu, Adams, Singleton, Clark-Carter & Kidd, 2009) illustrates that female doctors involve patients more in the decision making; gather more information on psychosocial issues than male doctors. Female doctors are more empathetic in their communication style and spend longer time with their patients; they also seem to make more referrals to hospitals and thus, said to be less cost-effective (McKinstry, 2008). On the other hand, longer consultations and patient-centered consulting styles lead to better patient outcomes and in the long run are cost-saving (Dacre, 2008).

According to literature gender has a predisposing influence in communication, as it is said that men and women differ in their styles of communication (Street, 2002; Tannen, 1990). Women generally talk and tend to build community and rapport, whereas men use talk as a means of establishing status and independence. The language is perceived to be of aesthetic quality (pleasing) but less dynamism (strong and active)

than the discourse of men. In the nonverbal domain, women are said to be more expressive and accurate at perceiving the emotions of others than the men. Also, female concordant visits relative to male concordant visits show they need more emotionally responsive including more psychosocial information and more patient-centered and less verbally dominated by the physician (Noro, Roter, Kurosawa, Miura & Ishizaki, 2018)

Research shows that men and women are being ascribed in different ways to communicate (Andersson, Salander, Brandstetter-Hiltunen, Knutsson & Hamberg, 2008; Salander & Hamberg, 2005). They also demonstrate different attitudes toward treatment (Ziefle & Schaar, 2011) and use different ways to perceive information (Dearborn et al., 2006). Such assumptions may result in gender bias and unequal care (Hamberg, 2008; Risberg, Johansson & Hamberg, 2008; Thornton et al., 2011).

Women's communication is said to be more emotional, subjective, polite and self-revealing and shows more concern and awareness of the feelings of others (Aries, 1998). Women's verbal behaviour is reflected in non-verbal communication and they express and interpret emotions through non-verbal cues more accurately than men (Hall, 1998; Sandhu et al., 2009).

Female patients tend to seek more empathic listening and longer visits. The psychosocial complexity among female patients is said to be higher (Linzer & Harwood, 2018). These authors found that the women had high hopes for empathic care and they associated that with being listened to. Patients are said to differ by gender in their expectations (Roter et al., 2004), this study also showed that the female patients expressed satisfaction towards their female physicians, when their communication style was caring, which was expected, while it did not matter when the male physician demonstrated a caring communication style (Mast, 2007).

In summary, a majority of studies take into consideration the communication aspects that occur during a medical encounter but comparatively not many have examined both culture and communication and how both concepts are interconnected in

doctor-patient interaction. The following review of studies highlights how communication and culture impact health care interaction.

2.3.3 Communication Differences between Doctors and Patients

A few scholars became aware of the importance of looking at the intersection of health, communication, and culture. Their research initiated discussions on communication aspects that should be considered when attempting to identify and describe culturally competent communicative behaviours. The following Table 3 gives an overview of studies carried out over a span of 20 years i.e. from 1995- 2015. They highlight the communication aspects and in just a few studies the cultural aspects are looked into.

Study	Country	Aim	Sample	Method & Analyses	Culture
Bowes & Domokos (1995) [32]	UK	Explore South Asian women's experiences and use of health services	20 Pakistani Muslim women (17 born abroad)	UII Thematic	Yes
Punamaki & Kokko (1995) [33]	Finland	Describe and analyze patients' consultation experiences	127 patients or parents of patients (60F, 67M) (ENR)	SSI Thematic	No
Johansson, Hamberg, Lindgren & Westman (1996) [34]	Sweden	Explore female patients' experiences in consultation	20 Swedish female with musculoskeletal disorders	SSI Grounded The	No
Thom, Campell & Alto (1997) [35]	USA	Identify physician behaviours that foster trust	29 patients (1 FG Hispanics, 1 FG African Americans, 2 FG not reported but inferred as White Americans) (20F, 9M)	4 FGs Grounded Theory	Yes
Rodriguez, Bauer, Flores-Ortiz, Szkupinzki-Quiroga (1998) [36]	USA	Identify provider related factors that may affect patient-provider communication about abuse for immigrant	14 Hispanic and 14 Asian women (n = 28)	4 FG: 2 Hispanic, 2 Asian Thematic	Yes
Pollock & Grime (2002)[37]	UK	Compare physicians' and patients' perspective of time constraints	60 adults diagnosed with depression (ENR)	II Thematic	No
Beresford & Sloper (2003) [38]	UK	Identify factors that hinder or facilitate communication	63 adolescents with chronic physical illness (36F, 27M) (ENR)	SSI Thematic	No
Gask, Rogers, Oliver, May & Roland (2003) [39]	UK	Explore experiences of care that depressed patients receive from their providers	27 patients with mild depression (19F, 8M) (ENR)	SSI Thematic	No
Walter, Emery, Rogers & Britten (2004) [40]	UK	Examine women's perspectives of optimal risk and communication	34 native English-speaking women in menopause, 6 nonnative English-speakers (n = 40)	FG & 4 SSI	No
Ziviani, Lennox, Allison, Lyons & Del-Mar (2004) [41]	Australia	Identify critical factors and obstacles to effective health communication	3 adults with intellectual disabilities (2F, 1M) (ENR)	SSI Thematic	No
Dubé, Fuller, Rosen, Fagan, O'Donnell (2004) [24]	USA	Examine communication issues important to men on cancer screening topics	29 White, 8 Black, 5 Hispanic, 11 biracial, other and unspecified men (n=53)	8 FGs Thematic	No
Ellis & Campbell (2005)	USA	Explore the importance of concordant spiritual belief systems in patient physician interactions	ewish, 6 Christian, 2 Agnostic, 1 Buddhist (6F, 4M) (n =	SSI Thematic	No

O'Day, Killeen, Sutton & Lezzoni (2005) [44]	USA	Explore perspective of psychiatrically ill patients receiving primary care	11 Caucasian, 5 other with chronic psychiatric disorders (8F, 8M) (n = 16)	FG Thematic	No
Sankar & Jones (2005)	USA	Understand patient's perspective on information disclosure	26 African American, 8 Asian, 5 Hispanic, 39 White, 4 Other women (n = 85)	II Thematic	No
Ali, Atkin & Neal (2006)	UK	Understand the ways in which White and South Asian patients communicate	7 White, 18 South Asian (21F, 4M) (n = 25)	Video recall and SSI Thematic	Yes
Cant & Taket (2006) [46]	UK	Explore lesbians' and gays' experiences of primary care	18 White, 5 Black and other ethnic minority (13F, 10M) (n = 23)	FG Grounded Theory	Yes
Moffat, Cleland, van der Molen & Price (2006) [47]	UK	Explore patients' experiences of consultations regarding asthma	14 patients with severe asthma (8F, 6M) (ENR)	SSI Grounded Theory	No
Towle, Godolphin & Alexander (2006) [48]	Canada	Understand the complexity of physician-patient communication in Aboriginal communities	26 Aboriginal patients (22F, 4M)	8 SSI & 3 FGs	Yes
Vickers, Jolly & Greenfield (2006) [49]	UK	Explore knowledge, attitudes, and behaviours about herbal medicine and	18 White British female herbal medicine users	II Thematic	No
Abdulhadi, Shafaee, Freudenthal, Östenson & Wahlström (2007) [50]	Oman	Explore views of type 2 diabetic patients regarding medical encounter	27 Omani type 2 diabetes patients (14F, 13M)	4 FG Thematic	Yes
Borgsteede, Deliens, Graafland-Riedstra,Francke, van der Wal & Willems (2007) [51]	Netherlands	Explore patients' experiences of communicating about euthanasia	12 patients with short life expectancy (ENR)	SSI Thematic	No
Fagerli, Lien & Wandel (2007) [52]	Norway	Explore patients' experiences of medical encounters	15 Pakistani born type 2 diabetes patients (11F, 4M)	SSI Phenomenology	Yes
Kokanovic & Manderson (2007) [53]	Australia	Describe the way patients in an Australian setting are told of diabetes	8 Chinese, 8 Indian, 8 Pacific Island, 8 Greek type 2 diabetes patients (16F, 16M) (n = 32)	SSI Thematic	Yes
Lowe, Griffiths & Sidhu (2007) [54]	UK	Explore attitudes and experiences of South Asian women towards contraceptive service provision	19 Pakistani women (2 born in UK, 17 born abroad)	SSI Grounded Theory	Yes

Mercer, Cawston & Bikker (2007) [55]	UK	Explore patients' views on determinants of quality of consultations in an economically deprived community	72 White Caucasian low SESi patients (44F, 28M)	11 FGs Grounded Theory	No
Oliffe & Thorne (2007) [56]	Canada, Australia	Explore male patients' experiences of interactions with male physicians about prostate cancer	33 Australian, 19 Canadian men with prostate cancer (n = 52)	SSI Thematic	No
Julliard, Vivard, Delgado, Cruz, Kabak & Sabers (2008) [57]	USA	Clarify which conditions reinforce nondisclosure of health information in clinical encounters between Latina patients and their physicians	28 Hispanic women (8 born in US , 20 born in South or Central America)	SSI Grounded Theory	Yes
Nguyen, Barg, Armstrong, Holmes & Hornik (2008) [58]	USA	Examine elements of physician-patient cancer communication from the viewpoint of older Vietnamese immigrants	20 Vietnamese immigrants	SSI Grounded Theory	Yes
Smith, Braunack-Mayer, Wittert & Warin (2008) [59]	Australia	Examine men's experiences of communicating with physicians in order to describe qualities and styles of communication that men prefer	30 Australian, 6 British men (n = 36)	SSI Thematic	No
Shelley, Sussman, Williams, Segal & Crabtree (2009) [60]	USA	Compare patients' and physicians' perspectives on communication about complementary and alternative medicine	40 Hispanic, 5 Non-Hispanic White, 48 Native American (72F, 21M) (n = 93)	SSI Thematic	Yes
Wullink, Veldhuijzen, van Schrojenstein, de Valk, Metsemakers & Dinant (2009) [61]	Netherlands	Explore preferences of adults with intellectual disabilities based on positive and negative experiences of communication	12 adults with intellectual disabilities (8F, 4M) (ENR)	2 SSI & 1 FG Thematic	No
Matthias, Bair, Nyland, Huffman, Stubbs, Damusb & Kroenke (2010) [62]	USA	Compare patients' experiences of communication with nursing staff and communication with physicians	ults with musculoskeletal pain and depression (11F, 7M) (	4 FGs Thematic	No
Peek, Odoms-Young, Quinn, Gorawara-Bhat, Wilson & Chin (2010) [63]	USA	Examine African American patients' perceptions of the influence of race on physician-patient communication	51 African American with diabetes (42F, 9M)	24 SSI & 5 FGs Phenomenology	Yes
Yorkston, Johnson, Boesflug, Skala & Amtmann (2010) [64]	USA	Explore patients' experiences of communication about pain and fatigue	22 White, 1 Black adult with chronic pain (18F, 5M) (n = 23)	FG Thematic	No

Jagosh, Boudreau,Steinert, MacDonald & Ingram (2011) [65]	Canada	Understand patients attitudes, perceptions, and thoughts about their communication experiences	55 adults (10 French-speaking; 45 English-speaking; 3 Bilingual) (32F, 26M)	SSI Thematic	No
Jagosh, Boudreau,Steinert, MacDonald & Ingram (2011) [65]	Canada	Understand patients attitudes, perceptions, and thoughts about their communication experiences	56 adults (10 French-speaking; 45 English-speaking; 3 Bilingual) (32F, 26M)	SSI Thematic	No
Black (2012) [67]	USA	Explore elders' perspective of the influence of their beliefs on health care encounters	60 African American elders (30F, 30M)	SSI Thematic	Yes
Burton (2012) [68]	Guatemala	Explore the ways in which facework influences physician-patient interactions for Achi patients	24 Achi Aboriginal patients	SSI & Observations Thematic	Yes
Dahm (2012) [69]	Australia	Explore the relationship between perceived time constraints, jargon use, and patient information-seeking	7 Non-Native English-speakers from Europe and Asia, 10 Native English-speakers (14F, 3M) (n = 17)	SSI Grounded Theory	Yes
Hartley, Sutherland, Brown & Yelland (2012) [70]	Australia	Explore women's views of care provided by physicians in the first 12 months postpartum	29 women (ENR)	SSI Thematic	No
Holmvall, Twohig, Francis & Kelloway (2012) [71]	Canada	Explore patients' experiences of fairness and commitment in health care contexts	23 adults (15F, 8M) (ENR)	SSI Grounded Theory	No
Shannon, O'Dougherty & Mehta (2012) [72]	USA	Explores refugees' perspectives regarding communication barriers impeding on communication about war related trauma	37 Liberia, 3 Laos, 3 Asian, 4 Africa, 1 Bosnia, 3 South American (32F, 18M) (n = 50)	SSI Thematic	Yes
Weber & Mathews (2012) [73]	USA	Explore patients' perceptions of the quality of care delivered by a foreign international medical graduate physician	4 White, 5 Black, 1 Native American lower SES patients (6F, 4M) (n = 10)	SSI Thematic	Yes
Bergman, Matthias, Coffing & Krebs (2013) [74]	USA	Understand respective experiences, perceptions, and challenges both patients with chronic pain and physicians face communicating about pain	20 White, 4 Black, 2 Other chronic pain patients (2F, 24M) (n = 26)	SSI Thematic	No

Claramita, Mubarika, Nugraheni, van Dalen & van der Vleuten (2013) [75]	Indonesia	Examine cultural relevance of Western physician-patient communication style to Indonesian physician-patient interactions from the patients' and physicians' perspective	20 Javanese patients (Indonesian)	SSI Grounded Theory	Yes
Cocksedge, George, Renwick & Chew-Graham (2013) [76]	UK	Explore the use of touch in consultations from both physician and patient perspectives	10 White British, 1 other (n = 11)	SSI Thematic	No
Hughes (2013) [77]	USA	Explore women's experiences of communication about sexual health	13 White, 13 African American, 1 Native American women (n = 27)	SSI Thematic	No
Wilkinson, Dreyfus, Bowen & Bokhour (2013) [78]	USA	Examine communication and interaction as experienced by patients and physicians	23 White, 3 Black intellectually disabled women (n = 27)	SSI Grounded Theory	No
Baumbusch, Phinney, & Baumbusch (2014) [79]	Canada	Explore the perspective of adults with intellectual disabilities on helpful interactions with their family physician	11 adults with intellectual disabilities (7F, 4M)	SSI Thematic	No
Bayliss, Riste, Fisher, Wearden, Peters, Lovell, & Chew-Graham (2014) [80]	UK	Explore possible reasons why people from Black and ethnic minority groups may be less frequently diagnosed with chronic fatigue syndrome or myalgic encephalitis	6 Pakistani, 2 Indian, 2 Black British, 1 Other White patients with chronic fatigue syndrome (8F, 3M) (n = 11)	SSI Thematic	Yes
Marcinowicz Pawlikowska & Oleszczyk (2014) [81]	Poland	Identify which aspects of GPs' behaviour are the most important for older people in their perception of the quality of the GP visits	30 patients over the age of 65 (18F, 12M)	SSI Thematic	No
Matthias, Krebs, Bergman, Coffing, & Bair (2014) [82]	USA	Advance the understanding of communication about opioid treatment for chronic pain	7 African American, 23 White veteran patients with chronic pain (4F, 26M) (n = 30)	SSI Thematic	

Ritholz, Beverly, Brooks, Abrahamson, & Weinger (2014) [83]	USA	Explore perceptions of barriers and facilitators to diabetes self-care communication during medical appointments	34 patients with diabetes (82% non-Hispanic White) (41% female)	SSI Thematic	
Rose & Harris (2014) [84]	Australia	Explore the experiences of ethnically diverse patients with diabetes in receiving self-management support from GPs	11 Arabic-speaking migrants, 9 English-speaking migrants, 8 Vietnamese-speaking migrants (17F, 11M) (n = 28)	FG Phenomenology	Yes
Esquibel & Borkan (2014) [85]	USA	Explore ways in which opioid medication influences the doctor-patient relationship by exploring	21 patients receiving opioid therapy (13F, 8M)	SSI Thematic	No
Melton, Graff, Holmes,Brown, & Bailey (2014) [86]	USA	Explore the experience of asthma patients in the management of their illness	4 African American patients with asthma (4F)	SSI Phenomenology	Yes
Silver (2015) [87]	Canada	Explore barriers and facilitators of patient-provider communication about patient searches for health information on the Internet	56 elderly patients (57% born in Canada) (30F, 26M)	SSI Grounded theory and thematic	No
UII: Unstructured individual interviews. p: Cultural aspects are discussed. ENR: Ethnicity not reported.					
SSI: Semi-structured individual interviews. FG: Focus group interviews. II: Individual interviews. SES: Socio-economic status.					

Table 3: Overview of Studies on Communication and Culture

In many of the above research and other research not listed in the Table 3, it has been explored that the use of medical vocabulary and terminology, the use of statistical information in explaining the disease, its risks, may result in patients not fully or accurately understanding the news given or the treatment options presented to them (Drew, 2014)

Salimbene (2000), one of the contemporary scholars, provides in "*what language does your patient hurt in? A practical guide to culturally competent care*", extensive background information on African Americans, Native Americans, Asians, Hispanics, Middle Easterners, and ex-Soviet Union immigrants. The author explains that each group differs in expectations and beliefs regarding health-illness but also observes the need for doctors to communicate in a culturally competent manner to

obtain successful interactions with patients. Tips to improve trust and understanding between the two interactants from race- discordant backgrounds particularly when culture and linguistic barriers hinder successful communication and relationship building. However, the author ignores the fact that both interactants negotiate and co-construct the relationship through their communicative behaviour.

Schouten and Meeuwesen (2006) reviewed research between 1974 and 2004 on culture and ethnicity in interactions between doctors and patients. They found that as opposed to majority groups, ethnic minorities were less likely referred for medical treatment and lower levels of compliance existed among patients concerning treatment instructions. They concluded that inadequate attention was paid to communication and its consequences and that this area was inadequately theorised.

These studies carried out on physician-patient interaction most frequently involved a comparison of doctor-patient communication between visits of patients belonging to one of the major ethnic minority groups and white physicians, on the one hand, and visits of white patients to white doctors, on the other hand. In the American studies, ethnic minority patients were African, Americans and Hispanics; in the Dutch studies they were mainly of Surinamese, Antillean and Turkish or Moroccan background and in the Australian study, they were Aboriginals (Schouten & Meeuwesen, 2006).

In addition to all the above-mentioned aspects such as language, non-verbal cues, gestures, goals, expectations that are said to create differences and misunderstandings between doctors and patients, the manner in which doctors deliver a diagnosis and prognosis to a patient can also be culturally different. Researchers (Rao, Lee et al., 2002) state that doctors in the West prefer to disclose the whole truth about the patient's condition as this phenomenon has "*its roots in legal rights and medical ethics but it is also embedded in the communication style of the American culture, for example, which praise the exchange of direct and straightforward messages*" (p.5).

This directness is said to be embedded in a cultural value of low context and individualistic cultures that presuppose communication should be contained in words leaving little doubt about the explicitness and clarity of the message transmitted.

On the contrary, doctors in Argentina, Brazil, and India use half-truths due to being high context cultures (Torres, 2007). Most of the communication is not necessarily encompassed verbally with words but it presupposes that the interactants will read the context in which the meaning is transmitted (Samovar & Porter, 2001).

Telling a patient that s/he is terminally ill is not necessarily verbalised as it is a belief that the patient can read the graveness of his/her condition based on the situational clues such as the number of tests, frequent visits to the doctor, etc. As people in collectivistic cultures are said to be "*highly sensitive to the effect of what they say on others ...speakers must weigh their words carefully. They know that whatever they say will be scrutinised and taken by heart"* Cohen (cited in Ting-Toomey, 1994, p.362).

Ting-Toomey (1994) explains that in these cultures; "*it is up to the interpreter of the message to pick up the hidden meaning or intention of the message and to respond either indirectly or equivocally*" (p.366). Undoubtedly, this way of communication is embedded in cultural values, beliefs and norms and face-saving. Doctors tend to preserve the patient's face and not emotionally disturb the patient if they feel the individual is not psychologically ready to receive such news (Penman, 1994; Samovar & Porter, 2001).

Also, as mentioned earlier in this section 2.3.3, the use of medical jargon by doctors in their consultations can result in the danger of misunderstanding. The language employed by doctors is generally a mixture of everyday language and medical terms. Often the medical jargon is incomprehensible for the patient and it is also quite likely that the same term may have a different meaning to the patient. For example, a study on lay beliefs about germs and viruses found out that it was believed that both were considered vulnerable to antibiotics and these drugs were desired and demanded

by patients as a treatment even though the diagnosis was a viral infection (Helman, 2007).

An important theory in the field of communication is the Communication Accommodation Theory (CAT) inspired by Coupland and Giles (1988). CAT theorises the communication strategies, tactics and behaviour interactants use to attempt successful communication. This theory is employed too in the field of patient-doctor communication (Street, 2001; Watson & Gallois, 1998). It not only deals with motivated, mutual communication but also includes additional accommodation strategies such as emotional expression (Watson & Gallois, 2007).

In the CAT, accommodation is a process concerned with how interactants reduce and magnify communicative differences in their interaction. Accommodation is considered an important route to achieving communication and this is done by enhancing interpersonal similarities and reducing uncertainties about the other. The effect of converging or approximating another shows and increases liking for the "*converger*", enabling him/her to be seen as more competent and credible (Aune & Kikuchi, 1993).

Convergence can occur in the communication dimension in various forms like switching to the other's language or assuming the same level of the others' interruptions, speech rate, etc. (Li, 2001). These adjustments can be called upward/downward convergence. The former is when a speaker adopts another's more prestigious accent, whereas the latter is when a speaker adapts to match another's more colloquial speech pattern. For instance, when a doctor uses lay words and explanations when speaking to his /her patients instead of medical jargon.

Accommodation can also be manifested in many ways other than convergence, for example, by taking into account the other interactant's conversational needs and goals (Jones, Gallois, Callan & Barker, 1999). For example, accommodating "*interpretive competence*" i.e. the ability to understand whether the other interactant has had any experience with the topic or event being discussed.

On the other hand, non-accommodative practices can also occur and in different facets, too. This can be manifested in "*speech maintenance,*" where the speaker sustains a consistent communicative stance from person to person irrespective of who the latter may be to maintain an aura of authenticity. Underaccommodative can also be the case where they do not attend or listen to another's needs. Divergence of language like speaking in a different accent has been considered most in interpersonal encounters where interactants feel they are representing different groups, cultures, and communities with which they strongly affiliate and where their in-group language or communication style is a fundamental dimension of their social identity (Jones et al., 1999).

Fairclough talks of "*order of discourse*" as a "*totality of discursive practices of an institution and relations between them*" and "*genre*" as a socially ratified way of using language in connection with a particular type of social activity (1995, p.135). This relates closely and clearly to the small culture dynamics explained in section 2.6 and Figure 4.

2.3.4 Cultural Sensitivity and Communication

Ulrey and Amason (2001) feel a medical encounter should be sensitive to patients' values, beliefs, and expectations that are different. Cultural insensitivity "*leads to miscommunication*" (p.451) which causes problems in the diagnosis, prognosis and patient treatment. Being interculturally effective helps both interactants as it helps the patient in regaining his/her wellbeing and is also less stressful for doctors.

Since miscommunication is said to cause problems and disparities, to effectively address and deal with disparities in healthcare, the notion of culturally competent healthcare has emerged as an umbrella that captures the sensitivity to racial and ethnic cultures in healthcare delivery (Betancourt, Green, Carrillo & Park, 2005). Although cultural competency in healthcare is in the formative stage (Paez, Allen, Carson & Cooper, 2008; Perloff et al., 2006) current research states the patient-centeredness is an important component of culturally competent healthcare.

Not incorporating patient-centeredness leads to inappropriate stereotyping despite the doctor's best intentions (Hund & De Voogd, 2005). Also, identifying patients' values alone without giving them adequate opportunities to voice their concerns does not enhance the quality of care (Kawaga-Singer & Blackhall, 2001).

Although patient-centeredness is recognised as an important element, there is less empirical research on doctors' on-the-ground work and specific strategies for achieving patient-centeredness in inter-ethnic, cross-cultural settings (Ming-Cheng, 2010). Mead and Bower (2000) suggest a five-dimension framework for patient-centeredness: biopsychosocial perspective, patient-as-person, sharing power and responsibility, therapeutic alliance and doctor-as-person.

Mishler (1984), on the other hand, explains that the patients' illness experiences are the voice of their lifeworld, which is oriented to meanings, understanding of everyday life as opposed to the voice of medicine, which is technology-centered and goal-oriented. The biomedical framework of the doctors reduces the lifeworld of the patients to a set of abstract symptom presentations that are treated like the scientific basis for diagnosis and treatment options (Good & Good, 2000; Hunter, 1991).

This suppression of the lifeworld of the patients can result in distorted communication, erratic diagnoses, or inappropriate treatment plans (Barry et al., 2001). A lot of literature also posits the healing power of narrative itself – patients need to be heard, understood and not just cured for the completion of the healing process (Brody, 1994; Frank, 1995; Hunter, 1991; Kleinman, 1988; Mattingly, 1998). The art of listening makes modern medicine more humane and allows doctors to become complete caretakers (Charon, 2001; Connelly, 2005).

The significant increase in diversity has also made some health communication scholars voice their concerns. Kreps and Kunimoto (1994) point out three main ideologies that dominate in a host country, namely: cultural segregation, naïve

integration, and pluralistic integration. Cultural segregation is said to take place when individuals who are different from the dominant culture are marginalised, segregated and pushed to communicate in the ways individuals from the dominant culture do. People from the dominant culture behave and respond in an ethnocentric manner towards those individuals from a different culture where they devalue and reject the way diverse populations communicate and behave.

Ethnocentrism may generate feelings of mistrust, insecurity, prejudice, and discrimination (Ahmadi, Shahmohamadi & Araghi, 2011), and, therefore, is destructive during cross-cultural interactions (Pocovnicu &Vasilache, 2012; Reichard, Dollwet & Louw-Potgieter, 2014). Ethnocentrism may reduce the motivation to interact with diverse cultures (Arasaratnam & Banerjee, 2007), foster feelings of superiority and even hinder intercultural communication (Gudykunst & Kim, 2003).

The second ideology of naïve integration permeates when respect is shown to cultural differences as long as these individuals behave and communicate like individuals from the mainstream culture. The last ideology pluralistic integration advocated by the authors implies not only respect for cultural differences; but also encourages diverse individuals to maintain their perspectives. So, to respect and to integrate culturally different individuals, it is important to work on and establish competent and sensitive communication in the health care setting.

The authors (Kreps & Kunimoto, 1994) propose a list of suggestions at the individual level to "*promote effective multicultural relations in the health care contexts*" (p.111). These suggestions aim to move the doctors from an ethnocentric mindset where s/he is unaware of differences and to expose him/her to cultural differences so that his/her communication behaviours with patients of different cultural backgrounds become appropriate and competent. However, suggestions are provided for only one interactant i.e. the doctors although a consultation involves a relationship with the patient. This limits the fact that competences are negotiated in the doctor-patient interaction and enacted through communication.

The shift from an ethnocentric worldview of doctor-patient communication, to a sensitive and integrative model of cultural diversity, is also acknowledged by Geist (1997). She argues that the movement of health care delivery should be more culturally sensitive as it is limited by western medicine that stresses biomedical aspects. This compliance with western medicine ignores "*the task of communicating to negotiate understanding"* (p.341). She feels that it is important to understand the expectations and beliefs about health-illness that both interactants bring to the medical encounter as this is something that is negotiated by both parties.

She believes that listening to patient narratives and constructing a partnership with the patient will help both the interactants to negotiate "*cultural understanding*" (p.347) so that both parties communicate to meet their needs. Although she acknowledges the need to negotiate cultural differences to meet their needs, she only focuses on linguistic and cultural aspects of the health belief models that affect communication and ignores the other relevant

2.3.5 Migrant Health

In addition to the three areas of inquiry that this research is set in, further research shows that there are additional possible aspects to be taken into consideration when working with the immigrant population in a medical setting (Bertera, Bertera & Shankar, 2003; Hovey & Magana, 2000; Potocky-Tripodi, 2002; Solis, Marks, Garcia & Shelton, 1990).

There are different definitions of the term immigration. According to international definitions, immigration occurs when a person moves his/her centre of living over a socially meaningful distance. When this movement is across national borders, it is defined as international immigration (Spallek, Zeeb & Razum, 2010). In Austria groups of immigrants are defined based on nationality and no difference is made between foreigners and immigrants. Although foreign citizenship does not always equate to an immigrant background, as there are people with foreign citizenship, who

were born in Austria and did not migrate themselves or immigrants who have obtained Austrian citizenship through naturalisation.

Immigrant groups are heterogeneous they can be workers, contract and seasonal workers, scientists as well as those with restricted stay permits. In addition, there are also groups of refugees and asylum seekers with families. Immigrants are made up of sub-groups that differ to some extent from the majority population. Differences arise due to factors such as the primary reasons for migration, lifestyles (nutrition, etc.) or discrimination due to migrant origin. Immigrants are more likely to have a below-average income, a lower education as well as unfavourable working and living conditions (Spallek et al., 2010).

Immigrants are considered a vulnerable group in terms of health and should be given proper attention in the field of health research. They differ from the majority of the population in terms of their health-related behaviour and the use of health care resources. Many have different cultural or traditional ways of life and frequently a different understanding of sickness and health. This may lead to differences in health-related habits in fields like nutrition, living and working conditions, etc. (Spallek et al., 2010).

Hovey and Magana (2000) explain, "*Immigrants may experience the breaking of ties to family and friends in their country of origin*", thus, resulting in feelings of loss and a reduction in coping resources. Immigrants may also experience factors that are specific to the new environment. These include discrimination, language inadequacy, a lack of social and financial resources, stress and frustration associated with unemployment and/or low income, feelings of not belonging to the host society: a sense of anxious disorientation in response to the unfamiliar environment (p.119).

Iannotta (2002) conducted research on birth outcome and identified that the "*healthy immigrant phenomenon*" also called selective migration identifies that people who choose to migrate may be the strongest and healthiest; may be highly motivated;

have strong psychological, emotional and family ties; and may actually have the economic resources to make the move (p.17).

Furthermore, the degree of acculturation and assimilation that also play a role, have also been examined among immigrant patients. Health communication scholars have attended to culture by asking why some groups acculturate more than others and how acculturation affects the understanding of the health and behaviour of the racial and ethnic populations. Acculturation is defined as "*the changes that an individual experiences as a result of being in contact with other cultures and participating*" (Berry, 1990, p.460). It is a voluntary process where the immigrant is encouraged to understand and to acquire the traditions and customs of the host country. Although voluntary in nature, the more visible the differences between the immigrant and the host country, the higher the pressure the immigrant may feel to acculturate.

In fact, the immigrant may feel the pressure not only to acculturate but also to assimilate to the host country. "*Assimilation means becoming the way like the members of the dominant culture*" (Spector, 2004, p.17), whereas acculturation is the process of adapting to and adopting certain host cultural ways of being. Spector (2004) explains that to assimilate means that the immigrant would discard his/her cultural identity for an entirely new identity. Although identity is a dynamic concept and is continually changing, it is not possible to fully discard one's identity, as it is part of one's culture and frame of reference.

Characteristics of one's identity can change but the self is socially constructed and it will always be a product of culture. Acculturation is a difficult and slow process as the immigrant has been enculturated with his/her own cultural set of beliefs, customs, and traditions since birth. Many groups undergo to some degree acculturation over time, where cultural attributes of the larger society are incorporated to some extent. Medical students, for example, also undergo the process of acculturation as they acquire the culture of the career over many years; they acquire a very different perspective on life than those who are outside this profession.

Although the process of acculturation and assimilation may be seen as a positive process by the host culture as it can maintain the dominant position of power through these processes, they can also have negative effects on the immigrants' health.

The immigrant may face acculturative stress, which leads to different, even perhaps bad health behavior, to affective disorders such as depression. Spector (2004) explains that "*the dominant society expects that all immigrants are in the process of acculturation and assimilation and that the worldview that we share as health care practitioners is commonly shared by our patients*" (p.18). Some immigrants may feel as mentioned earlier the pressure to assimilate and may resist any degree of acculturation. Thus, doctors should be culturally sensitive to understand that there are differing degrees of acculturation and to acknowledge different worldviews considering care and treatment regimen.

Moreover, the acculturation progression of an individual depends also on the permanence of the situation, on the valuation of one's home cultural identity and the relationships held in the host society. There are four types of attitudes towards acculturation: integration, assimilation, separation, and marginalisation (Navas, Rojas, Garcia & Pumares, 2007).

Studies on long-term adaptation state that immigrants face adaptive change over time within themselves and in their relationship to the host environment. Taft (1966) delineated seven stages of assimilation of individual immigrants, moving progressively from the "*cultural learning stage*" to the "*congruence stage*". Numerous studies have provided evidence that there is an incremental and progressive trend of adaptation. An underlying assumption of these studies has been that long-term settlers, who live and work in a new environment, need and want to be better adapted to the local language and cultural practices to achieve some level of efficacy in their daily lives (Jackson, 2012).

Kim (1988, 2001, 2005) came up with the integrative communication theory of cross-cultural adaption which brings together many of the existing perspectives, concepts, theories and research findings on short-term and long-term adaptation into a comprehensive communication framework. According to Kim (1995) adaptation can be seen as a dialectic relationship between push and pull, or engagement and disengagement and if this process functions well then the individuals are said to develop an "*intercultural identity*," which is a mix of the past and the present, whereby the original cultural identity gradually diminishes, losing its distinctiveness and resulting in an expanded, flexible self or definition of self.

Cross-cultural adaptation is defined as the phenomenon where individuals upon relocating in an unfamiliar environment strive to establish and maintain a relatively stable, reciprocal and functional relationship with the environment. When individuals enter new and unfamiliar cultures, they undergo to some extent new cultural learning i.e. the acquisition of native cultural patterns and practices in areas of direct relevance to the daily functioning. As new learning takes place deculturation or unlearning of some old cultural habits tend to occur in the sense that new responses are adopted in situations that would have evoked old, habitual ones.

An interplay of acculturation and deculturation occurs and it is the internal transformation that an individual undergoes in the direction of assimilation. Individuals vary by choice or by circumstances in their adaptation process. This is, however, not a smooth linear process but a cyclical, fluctuating pattern of drawbacks and leaps. Each stressful experience is responded to with a temporary setback and then it activates adaptive energy to reorganise and rearrange in the activities of cultural learning and internal change that brings about new self-reintegration.

Based on the above-mentioned considerations, it could be assumed that immigrant populations would have and perhaps face health care disparities. However, they may also experience positive outcomes as regards health and this paradox may be reflective of the number of years the immigrant has lived in the host country and the

degree of acculturation within the host country. To understand such health-related paradoxes, researchers have examined migration factors, gender roles, the effects of acculturation and the "*dual frame of reference*" phenomenon.

Suarez-Orozco (1989) termed a "*dual frame of reference*" resulting in the immigrant patient accepting treatment without questioning the quality of care. This dual frame of reference leads to trust and even faith. The immigrant may trust his/her doctor because the provider may seem more knowledgeable as compared to doctors in the patient's home country.

Furthermore, technological advances may also support this frame of reference. The doctor is often elevated to an authoritarian status and the immigrant may not question him/her out of respect, consideration of authority, expertise and trust. The dual frame of reference can lead to the acceptance of care; it can also lead to acceptance of inadequate care which is unknown to the patient.

As regards the participant group women immigrants interviewed in this research as well as referring to the above literature, it can be said that all the women interviewed in this research belong to the *"healthy immigrant phenomenon"* as they have willingly chosen to migrate to Austria due to family or personal reasons. All of them are educated women, working professionals and *"recent immigrants"* so to say, as they have been living in Austria for less than 10 years.

2.4 INTERCULTURAL HEALTH COMMUNICATION

Rao and Beckett (2000) sustain that every encounter between a doctor and a patient is intercultural in its nature. An assertion, which holds given the fact that both interactants bring in their different health belief models to the medical encounter and they both understand as well as communicate about health- illness differently. The literature reviewed in this section in 2.4.1.1 illustrates key themes that are essential for

contextualising and understanding doctor-patient interaction when both interactants come from diverse cultures.

Literature also emphasises the need for doctors to acquire good communication skills to be perceived as competent by the patients. It also refers to training for patients so that they can understand better and voice their expectations during a medical encounter. However, these studies have left out cultural aspects that are indissolubly linked with communication in general, as well as in the field of health care, and clearly expectations and perceptions of patients coming from diverse cultures may well be different from the perceptions held by their physicians.

2.4.1 Summary and Limitations of the Literature

Literature in this field has its limitations. Many studies do not see the close connection between communication, health, and culture. Though a language barrier is an important aspect that cannot be overlooked in an interaction, it is not the only hindrance. Failure to consider the different expectations, disclosure and context meaning has a deep impact on how cultural competence gets constructed in the medical environment.

This literature is mainly prescriptive as it provides information concerning how doctors' and patients' health beliefs differ and how these models vary across cultures. Thus, it can be said that the underlying assumption is to understand and to acknowledge that both interactants i.e. the doctors and the patients hold different health belief models, however, this literature does not assess what happens when two individuals from two different cultures interact in the medical environment.

2.4.1.1 Essentialist View in Literature

Many studies neglect considering culture's influence on patients' experiences, despite previous evidence demonstrating culture's potential influence on communication (Harmsen, Meeuweseen, van Wieringen, Bernsen & Bruijnzeels, 2003; Schouten et al., 2006; van Wieringen et al., 2002). Cultural aspects at play in communication are not explored frequently in previous reviews as listed in Table 4.

The body of literature reviewed so far also tends to be very prescriptive and normative in nature where ethnicity, nationality is predominantly taken into consideration, which can be seen in all the cross-cultural studies highlighted in this literature review. Hofstede (1991) whose dimensions have been used in the literature, is known as the protagonist of this view. Neglecting culture or reducing it to *"race"* or *"ethnic"* categories tends to overlook sociocultural issues (Lee, 2009). The essentialist view sees culture as a concrete social phenomenon that denotes as well as represents the core characteristics of a particular nation (Holliday, 1999).

In this manner, as researcher Collins (2018) states, "*the world is constructed as a collection of self-enclosed nations, its citizens are seen as a product of a nation's culture*" (pp.168-169). He explains how culture is predominantly defined as a large culture, is understood here as a physical entity that can be touched and experienced by others and behavior is confined to national culture. This view that sees large culture as a cohesive behaviour in any social grouping and all subcultures are contained within and subordinate to these large national cultures is shown in most of the studies. This approach often results in an easy generalisation of large cultures based on ethnicity and nationality and in "*reinforcing stereotypes and homogenizing cultures*" (Martin, Nakayama & Carbaugh as cited in Collins, 2018, p.169).

Furthermore, a large culture is presented as static and is treated as a variable. Large culture is reduced to a quantifiable factor or a cultural variable. In such cases, large culture is understood as a property of "*certain*" individuals, for example, those of ethnic and racial minority groups. Moreover, a large culture is often conflated with race

and identity and so the diversity within groups itself is not acknowledged. As the flexible, diverse, emergent quality and fluid nature of (small) culture is not recognised and captured, the variation in large culture is not taken into account, thereby resulting in a "*one size fits-all*" approach towards individuals.

Another interesting aspect that can be inferred from the following Table 4 is that most of the studies carried out over a period of 30 years from 1974-2004 are quantitative (12) and only two are qualitative in nature (Schouten et al., 2006). Quantitative methods predominate in these reviews. It is, indeed, difficult to reach definite conclusions about the variability of doctor-patient communication due to the varied research questions and research designs used in these studies. However, in most of the research, ethnicity has been used as a predictor variable to relate to differences in communication behavior; other predictor variables have not been incorporated so it is not possible to detect explanatory mechanisms with regard to the communication process nor is it possible to assess, which cultural variables have an influence on the communication process. Hence, although quantitative methods allow establishing associations between variables, qualitative studies should also be examined since they allow a profound and detailed understanding of patients' experiences.

In most cases, the frequency systems have been employed. Frequency counting of behaviour does not shed light on the dynamics of the communication process, which results in leaving essential aspects of difficulties in intercultural medical communication undetected. Researchers emphasise the need to consider the patient's lived experience in order to tailor interventions and communication and since culture plays a central role in the transmission and interpretation of messages, its influence should be explored (Ali, Atkin & Neal, 2006; Wheatley, Kelley, Peacock & Delgado, 2008).

Study	Country	Practice	Patient Sample	Doctor Sample	Observational Strategy	Observational Instrument	Inter-rater Reliability
Shapiro and Salzar [16] quantitative	USA	Resident Clinic	39 WA,15 LES-Hispanics, 7 ES-Hispanics (n=61)	10 WA family practice resident physicians	Audiotapes	Self-developed interaction analysis instrument	Range:0.50-0.61 (correlation)
Hooper et al. [17] quantitative	USA	Outpatient clinic of teaching hospital	67 WA, 74 Hispanics (n=150)	15 WA resident physicians (n=15)	Direct ratings of interaction through one-way mirror	Self-developed interaction analysis instrument	94% agreement
Erzinger [18] qualitative	USA	Family practice residency at public hospital	9 Hispanics (n=9)	Not reported	Audiotapes, transcripts	Conversation Analysis	NR**
Seijo et al. [19] quantitative	USA	Internal medicine clinic	51 Hispanics (n=51)	5 WA internal medicine physicians, 4 Latin American physicians	Direct ratings of interaction	Self-developed interaction analysis instrument	NR
Rivadeneyra et al. [20] quantitative	USA	Primary care clinic affiliated with university	15 WA, 19 LES-Latinos, 4 ES-Latinos (n=38)	3 WA, 4 Asian, 1 Middle Eastern primary care (resident) physicians (n=8)	Videotapes	Henbest & Stewart's Patient-Centeredness Measure	0.96 (correlation)
Sleath et al. [21] quantitative	USA	Family practices and general internal medicine clinics at university	153 WA, 254 Hispanics (n=407)	19 WA, 6 Hispanics, 2 Asian family practice or general internal medicine resident physicians (n=27)	Audiotapes, transcripts	Self-developed interaction analysis instrument	Range:0.80-0.93 (Cronbach'
Case et al. [22]	Australia	Satellite dialysis unit	5 Aboriginal (n=5)	5 White Australian physicians (n=5)	Videotapes	NR	NR
Van Wieringen et al. [23] quantitative	The Netherlands	General practices	48 Ethnic minority (mostly Surinamese/Turkish/Moroccan), 38 Dutch (n=87)	7 Dutch, 1 Aruban general practitioner (n=8)	Videotapes	Roter interaction analysis system	NR
Sleath and Rubin [24] quantitative	USA	Family practices and general internal medicine clinics at university	141 WA, 242 Hispanic (n=383)	19 WA, 6 Hispanics, 2 Asian family practice or general internal medicine resident physicians (n=27)	Audiotapes, transcripts	Self-developed interaction analysis instrument	Range: 0.61-0.87 (correlation)
Harmsen [25] quantitative	The Netherlands	Family practices	34 Ethnic minority (mostly Surinamese/Turkish/Moroccan), 32 Dutch (n=66), children	7 Dutch general practitioners (n=7)	Videotapes	Roter interaction analysis system	Range: 0.55-0.79 (correlation)
Sleath et al. [36] quantitative	USA	Family practices and general internal medicine clinics at university	177 WA, 236 Hispanics (n=403)	19 WA, 6 Hispanics, 2 Asian family practice or general internal medicine resident physicians (n=27)	Audiotapes, transcripts	Self-developed interaction analysis instrument	Range: 0.70-0.98 (correlation)

Sleath et al. [36] quantitative	USA	Family practices and general internal medicine clinics at university	43 WA, 44 Hispanics (n=98)	19 WA, 6 Hispanic family practice or general internal medicine resident physicians (n=25)	Audiotapes, transcripts	Self-developed interaction analysis instrument	NR
Cooper et al. [28] quantitative	USA	Primary care practices	110 WA, 142 AA (n=252)	13 WA, 18 AA, primary care physician (n=31)	Audiotapes	Roter interaction analysis system	Range: 0.45-1.00 (correlation): average doctor: 0.90, average patient: 0.86
Johnson et al. [29] quantitative	USA	Family practices and federal health centres	202 WA, 256 AA (n=458)	30 WA, 21 AA, 9 Asian/Indian Americans, 1 other primary care physicians (n=619	Audiotapes	Roter interaction analysis system	Range: 0.06-1.00 (correlation): average doctor: 0.88, average patient: 0.796

Table 4: Overview of Studies on Intercultural Doctor-Patient Communication: Setting, Sample and Method. Source: Schouten & Meeuwesen (2006)

*WA: White American, LES: limited English speaking, ES: English speaking, AA: African-American, *NR: not reported.*

Finally, the literature reviewed also highlights constructs and models that propose how doctors can move from the ethnocentric mindset and develop an ethnorelative view of the world to be able to provide culturally sensitive care in a medical setting. However, these models are one-sided i.e. for doctors only and the communication aspects in most cases have been ignored.

2.5 RESEARCH QUESTIONS

In view of the limitations pinpointed in the literature in the field of intercultural communication in the medical arena, based on the social constructionist paradigm, the focus of this research is to garner knowledge on women immigrants' perceptions of their medical encounter with their general practitioners (GP) as well as to gain knowledge on general practitioners' experiences during the medical encounter with women immigrants (WI).

As mentioned in section 1.3, it is known that various factors influence the communication process, so this study primarily aims to investigate:

1. Which dimensions impact the communication process?
2. What role, if any, does culture play in the communication process?
3. Does medical interaction impact women immigrants'illness management?

From the communication perspective, the focus will be on the reality created and interpreted by the participants of this study in a medical setting. It will aim to understand these realities constructed by them, for example, to understand what it means to women immigrants to be a patient, as well as to explore what it is like give medical advice to women immigrants from the general practitioners' perspective in the Austrian health care system.

Moreover, the social constructionist perspective focuses on how the interactants involved produce reality. It deals with understanding how the roles, rules, preconceived ideas, beliefs of the interactants influence the co-construction of the communication. As regards this study the aim is also to understand the communication dimensions and the cultural aspects that may impact communication.

2.6 CONSTRUCTIONISM THEORY IN COMMUNICATION

The theory of social constructionism states that humans actively interpret the world and construct meaningful understandings of it. It assumes that there are regularities in how people make sense of experience as well as in how interpretations inform actions and so it seeks to provide scientific accounts of those regularities. It views humans as agents, who interpret experiences and act based on these

interpretations (Kelly, 1955). Each individual has different systems of personal constructs that individuals develop and use to interpret events.

Communication is an intentional strategic activity in which people convey internal states to others in the effort to accomplish goals (Burleson, 1992). To be specific, communication is a process in which a person (the source) seeks to convey some internal state to another (recipient) through the use of signs and symbols (the message) in the effort to accomplish some pragmatic end (the goal). Thus, it can be said that communication proceeds through four related processes: message production, message processing or message reception, interaction coordination and social perception (Clark & Bly, 1995).

Message production – the process of generating verbal and nonverbal behaviour intended to obtain the desired response from others (Clark & Bly, 1995).

Message processing - interpreting the communicative behaviour of others to understand the meaning and implications of that behaviour. It involves not only grasping the meaning of the message i.e. what is said but the intention of those words (Clark & Bly, 1995).

Interaction coordination - the process of synchronising message production and message processing activities in a social episode to achieve smooth and coherent interchanges. This requires not only understanding and learning the social rules that govern in that specific setting but also to produce comprehensible, relevant messages that fit appropriately into the sequential structure of the particular interaction (Clark & Bly, 1995).

Social perception – is the process through which individuals make sense of the social world. Here individuals attend to cues, expressions to infer the thoughts and feelings of the interactant. Although social processing is not a communicative process per se where the production or processing or coordination of messages takes place. It is a cognitive process where making sense about others, which is effective for

communication. This plays an important role in all communicative conduct (Clark & Bly, 1995).

Thus, based on this paradigm, this study is designed to understand when the general practitioners and the women immigrants enter into a communicative relationship in a medical encounter if the internal state (message) conveyed by the women immigrants (source) is understood by the GP (recipient) and to what extent the GP (recipient) responds to the women immigrants' intended message (goal).

2.7 NON-ESSENTIALIST VIEW IN LITERATURE

In contrast to the essentialist cultural paradigm that orientates towards cultural determinism, reductivism, otherisation (Holliday, Kullman & Hyde, 2004; Nathan, 2015) and does not take into consideration the complexities of culture, on the one hand, and project the image of the positive self and the negative other (Holliday et al., 2004), the non-essentialist cultural paradigm stresses mainly on the context and the concrete when exploring culture (Young, 1996). Culture is seen as part of the knowledge that is context-laden, socially constructed and emergent rather than as a certain truth that can be widely applied.

As mentioned earlier in section 2.4.1.1, large culture is seen as static and literature is prescriptive and normative in nature, however, this study follows the non-essentialist view in order to fully understand the context i.e. the communication in the Austrian medical setting and the participants, who are the women immigrants and the general practitioners. The research sets to analyse the small cultural aspects that may emerge in the communication in the Austrian medical setting and views culture in its complexity.

2.7.1 Small Culture Concept

The social constructionist approach assumes that "*reality does not present itself in raw form but must be filtered through the person's own way of seeing things*" Littlejohn and Foss, (2005). This "*own way of seeing things*" is made up of personal constructs, delineated by similarities and differences and influenced by one's "*own culture*" (Sharf, Jenks & Vanderford, 1997).

Scholars (Lambert, Street, Cegala, Smith, Kurtz & Schofield, 1997) state that constructionist theories assume that a person's perceptions and behaviour go through a type of filtration system which is connected to identity. Some of the aforementioned researchers explain that social units such as family and larger community systems may influence individual identity, too.

In a similar vein, Holliday (2011) explains that ***particular social and political structures***, that comprise ***cultural resources*** such as nation, language, education, religion, etc. along with ***global position and politics*** i.e. power, affluence, economies, etc. have an influence on an individual's daily life and activities. The belief of Self and Other is also rooted in this structure. In addition, ***personal trajectories*** such as family, peers, profession, etc. play a role in creating and constructing the meaning of cultural reality. He also highlights that ***artifacts*** such as cultural practices, art, literature, etc. and ***statements about culture*** like the presentation of oneself contribute to one's meaning of cultural reality.

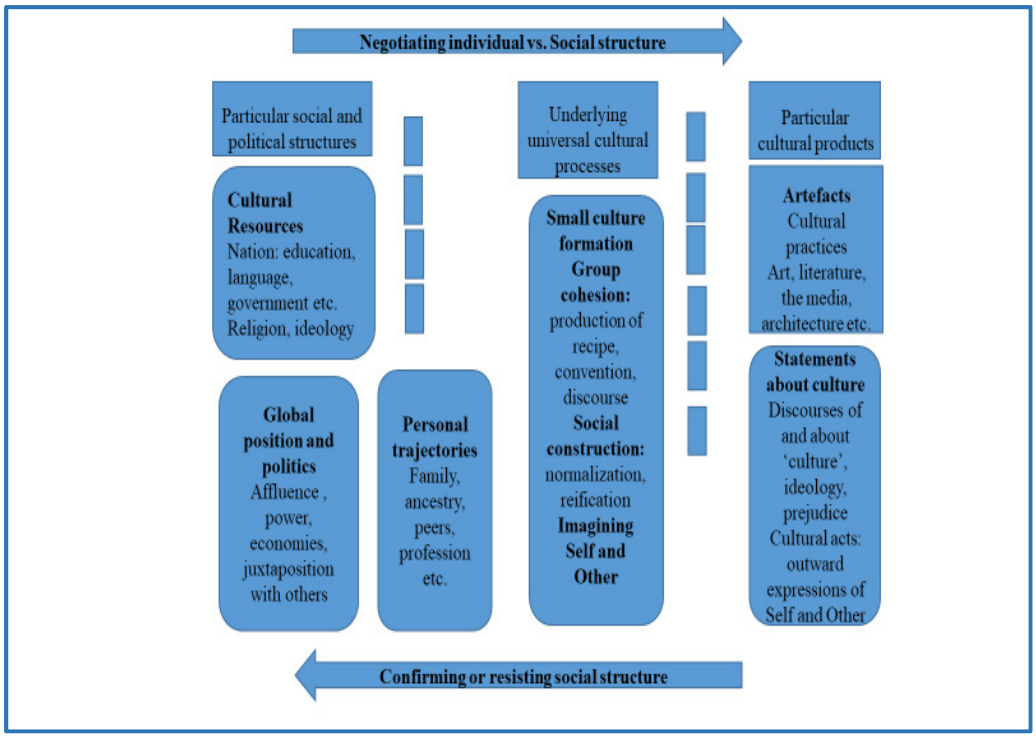


Figure 3: Aspects of Cultural Reality Source: Holliday (2011)

The above Figure 3 illustrated describes how individuals, in general, negotiate their aspects of cultural reality. The arrow moving from left to right shows the connection of social and political structures with the underlying universal cultural processes, which each individual possesses and influences his/her particular cultural realities. The personal trajectories, as well as the underlying universal cultural processes, enable individuals to introduce their cultural realities into existing structures. The arrow moving from right to left at the bottom of the figure indicate that the degree to how far the cultural negotiation is successful, which is subject to how far the existing structures are confirmed or resisted by the individual.

The ***underlying universal cultural processes*** that Holliday (2011) refers to are processes, which all individuals share, common across national borders, backgrounds, etc. They are skills and strategies used by all individuals to position themselves within the cultural landscape they come from or belong to. These underlying universal cultural processes come into operation in small cultural environments.

The **small cultural approach** described by Adrian Holliday (1999), has been employed in this research. As mentioned in section 2.4.1.1, literature sees culture as a variable, static in nature and it associates ethnicity and nationality with culture. Owing to the fact, that this research is based on the social constructionism paradigm and the fact that culture is seen as a fluid entity that perhaps influences the interactants during the communicative action, it has been decided to employ the small culture approach.

Small cultural environments are small groupings or activities where there is cohesive behaviour, where behavioural rules are formed that bind groups together. ***Small culture formation*** is said to be the basic cultural entity form where other cultural realities emerge and grow from. The small cultures are not necessarily subordinate to large cultures nor related to the essences of ethnic, national or international entities (Holliday, 1999).

The notion of small culture is heuristic in nature as the group behaviour is interpreted and may not have significant ethnic, national or international traits so to say. Here, the focus is more on understanding the social processes i.e. the communicative action and activities that take place in the medical setting. Since interactants operate meaningfully and try to make sense of the situation and circumstances, it can be said that the small culture is an ongoing dynamic process in changing circumstances. Dynamic in nature as it forms, and changes as required.

The dynamics of a small culture are explored without the preconceptions of national characteristics. How social behaviour operates in this small culture is investigated. For example, the different orientations that the interactants possess are analysed. The different orientations may be connected with different national scenarios with experiences of other types of political, educational cultures, etc. this would be discovered and not pre-defined. Thus, the major differences in the approaches of large and small cultures are summarised in the following Table 5.

Large and Small Culture Approach	
Large Culture Approach	**Small Culture Approach**
Essentialist i.e. culture causes behaviour	Non-essentialist i.e. culture emerges in any social group
Behaviour is confined and attributed to national cultures; and is cohesive in nature	Heuristic in nature; group behaviour is interpreted
Culture is static and seen as a predictor variable	Culture is seen as fluid that may influence the communicative action; dynamic process and changes as required
Simplistic in definition as people seen as less complex	Hard to define; complexities to be taken into account
Generalisation is easy based on nationality and ethnicity; non-stereotypical behaviour is coined as anomalous	Cannot generalise;interaction in the context with choice-makings; may be complex to understand
Subcultures are also contained to national tendencies	It may not be subordinate to large cultures; may not be related to ethnic, national entities

Table 5: Large and Small Culture Approach

2.7.2 Small Culture in a Medical Setting

Based on the definitions mentioned earlier, small culture can be defined as the sum of all processes, happenings or activities in which people habitually engage (Beales, Spindler & Spindler, 1967). Referring to the following Figure 4, which has been adapted based on the source figure on small culture formation by Holliday (1999), the small culture formation in the medical consultation can be explained as follows:

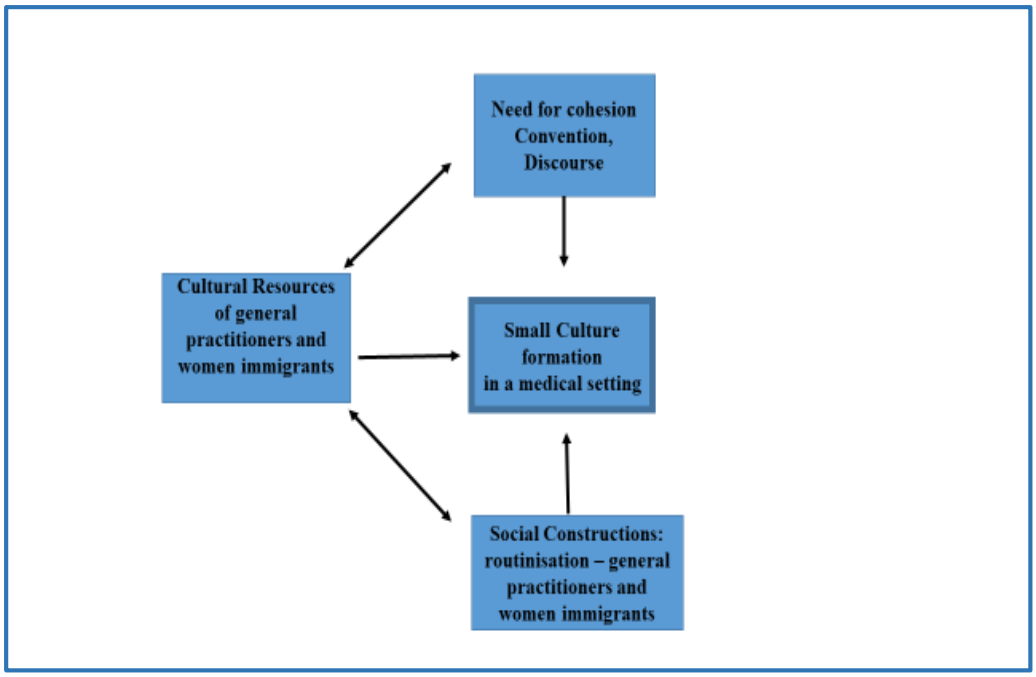


Figure 4: Small Culture Formation in a Medical Setting

Source adapted: Holliday (1999)

In this research, the interactants, who are women immigrants and general practitioners bring in their universal past experiences, beliefs, values, knowledge and personal trajectories to the small culture formation i.e. the medical setting. These *cultural residues* as named by Holliday (1999), have been coined as *cultural resources* by the researcher. These *cultural resources* of both interactants, which may constitute personal trajectories, national, political, religious and many more influences, serve as building blocks for the new small culture. Since these building blocks vary from person to person, the small culture that emerges is unique and dynamic in nature.

However, group cohesion is sought for in the small culture, which is marked by discourse, conventions, routines, etc. Discourse in the medical setting plays an underlying role, hence, small culture and language share a strong relationship as also stated by Sarangi "*discourse creates, recreates, focuses, modifies and transmits both culture and language and their interaction*" (1994, p.414). Hence, it can be said that the conventions and norms of that context i.e. the consultation process, as well as the

routinisation of both interactants in view of consultations, impact the small culture i.e. the consultation.

Based on this conceptual model, this research involving the dyads women immigrants and general practitioners aims at exploring the communication dimensions and the cultural realities they may bring in or draw on during their interaction in a consultation. It aims to understand the conventions, discourse, routines, challenges, and strategies employed by both participants in the medical consultation. This exploration of what aspects influence the communication and if any cultural aspects shape the interaction will be carried out through the analysis of in-depth interviews conducted with these groups of participants.

2.8 SUMMARY OF CHAPTER TWO

The three areas of literature dealing with culture and health, health and communication and intercultural health communication have been explored and dealt with. In doing so, it was found that the majority of the studies in the healthcare discipline acknowledge the existence of different cultural beliefs that are present and occur in every medical encounter.

Both doctors and patients display different health belief models that affect the perception of health, illness, and treatments. Although research stresses taking this aspect into account to become culturally competent, it is also proved that linguistic aspects affect the health care environment. However, the communication components of interaction are ignored.

The second line of research is from health and health communication where the doctor-patient relationship and communication are examined and the various variables are looked at but the intersection of culture is not considered. The third line of studies looks at the communication aspects present in intercultural interactions, the difficulties

and the complexities involved. Most of the research is prescriptive and quantitative in nature.

The literature critically reviewed tends to mainly follow the essentialist cultural perspective, which defines culture as static, prescriptive and normative in nature. Culture is considered a predictor variable and confines human behavior to national culture. This approach taken by dominant literature can be seen as a limitation. The anti-essentialist cultural paradigm is applied in this research, where the emerging culture in the context is explored.

Based on the social constructionism paradigm, this research study aims to employ the conceptual framework of a small culture approach to understand how the interactants negotiate and construct medical realities. It concentrates on understanding and elucidating how women immigrants and general practitioners construe and negotiate meanings in health care interactions, processes that appear in the small culture formed in the doctor-patient medical setting.

3 Chapter Three Research Methodology

3.1 INTRODUCTION

This chapter underlines the social constructionism paradigm and explains the phenomenological interpretive approach the research takes. It also expounds the reasons why a qualitative research methodology is most appropriate for this research. The selection of the setting, participants and the methods to be employed as well as how data will be collected and analysed are elaborated in this chapter.

3.2 SOCIAL CONSTRUCTIONISM PARADIGM

Research paradigms are "*based on ontological, epistemological and methodological assumptions*" (Guba & Lincoln, 1994, p.107). Ontology refers to "*the form and nature of reality*" (Guba & Lincoln, 1994, p.108). The epistemological assumption is directed to "*the nature of the relationship between the knower or would be-knower and what can be known*" (Guba & Lincoln, 1994, p.108). Finally, the methodological assumption states how the researcher could examine "*whatever he/she believes can be known*" (Guba & Lincoln, 1994, p.108).

This piece of research is based on the ontological position of constructionism that asserts that social phenomena and their meanings are continually being accomplished by social actors (Bryman, 2012). This means that social interaction gives rise to social phenomena and categories, which are constantly revised.

Social constructionism states that social reality is a product of social processes and is relative to context, time and culture; human beings construct it themselves (Holstein & Gubrium, 2008; Maltby, 2013). Social reality is constructed and is not independent of the people creating it. Thus, it can be assumed that participants, researchers and readers together, construct the research and in this way, the research is

produced by social interaction. Hence, the researcher presents a specific version of social reality rather than one which is said to be definitive.

In this study, the focus is on understanding how individuals construe and negotiate meanings in health care interactions, its processes and settings - in the doctor-patient medical setting.

3.3 PHENOMENOLOGICAL AND INTERPRETIVE APPROACH

This piece of research adopts a phenomenological and interpretive approach. Both these perspectives share the common idea that reality is socially constructed. The theory of phenomenology stems from three philosophers Georg Wilhelm Friedrich Hegel, Edmund Husserl and Martin Heidegger. Phenomenology emphasises the understanding of the world through the eyes of the individual who is viewing the world, and it gives priority to each person's point of view (Maltby, 2013).

Phenomenology acknowledges that many truths can exist and not only one truth. Knowledge results from uncovering each individual's perceptions, experiences, intuitive sense of what they think and feel in their different encounters with the world. The key to knowledge is obtained by fully understanding how individuals perceive the phenomena (i.e. the experiences around them and how they make sense of these phenomena (Maltby, 2013).

A phenomenological approach provides a more contextual approach to communication through probing, uncovering and interpreting the meanings of stories of patients (Greenfield & Jensen, 2010). This approach provides a coherent and genuine application of participants' perceptions, as it delves into the textured life-world of the participants. For phenomenologists, reality does not exist outside the individual's experiences but is embedded in the individual's conscious experience and it is re-created through shared meanings in communication with others.

Giorgi (2007) suggest that phenomenology is "*a study of consciousness*." The phenomenological view is an attempt to describe the lifeworld (Lebenswelt) i.e. lived experiences without making previous assumptions about the objective reality of those experiences. It is not only a philosophy but also a practice in the field of health care such as nursing. This concept of lifeworld (Lebenswelt) is central to modern phenomenology. The intent is to uncover the manifold meanings of participants' experiences. This approach also helps us to understand, on the one hand, participants' experiences, as this understanding is imperative to support doctors in understanding their patients more fully and potentially, and on the other hand, it is an aid to patients' compliance.

Husserl's philosophical quest was to explore how individual consciousness was formed. He believed that individuals are intentional beings, as the ideas and meanings that individuals develop are shaped by their experiences and reflections about things in the world. He argued that all individuals do not experience things and events the same way (Greenfield et. al., 2010). Husserl alludes to phenomenological intending which is the belief that individuals have a conscious relationship with an object, either externally or in his/her memory, which they interpret and develop meaning about.

Intentionality is based on the concept that individuals perform every act that consciously. He believed that individuals share a constant reciprocal relationship with their experiences of external reality. Subjective knowing cannot exist without objective experiences, as to understand the subjective meaning of things, individuals have to explore their experiences (intentionality).

In a similar vein, interpretivism believes that interpersonal relationships cannot be predicted nor reduced to a series of variables or behaviours that determine how causally a relationship is developed or maintained (Torres, 2004). Guba (1990) defines reality as a mental construction because it is created by individuals during their interactions. Moreover, interpretive inquiry aims to understand and then reconstruct the

constructions that actors hold about particular events during certain moments of their lives.

Interpretivism looks at social phenomena as the process of meaning creation through which individuals construct realities through their relationships with others. In the case of this study, it will focus on the "*lived experiences"*, on individual and unique experiences and include concrete examples as described and reflected upon by the participants selected, in view of the phenomenon i.e. their encounters with general practitioners/women immigrants in a medical setting.

Interpretive philosophy also forms the basis for hermeneutical methods of inquiry. Hermeneutics is the theory of the interpretation of meaning where an attempt is made to interpret the phenomenon in context. The term "*hermeneutic circle*" has its origin in the philosophy of Heidegger in the first half of the 20th century. In research, it means that the interpretation of texts (participants narratives) looks at parts of the "*lived experience,"* then at the whole and then back again, in a spiraling process, the end of which is achieved when the researcher has gained a reasonable understanding and meaning of the text. However, hermeneutic researchers believe that prior assumptions and preconceptions are important as these prior experiences might become source of knowledge and sensitise the researcher to meanings that might be present in the narratives of the participants (Matlby, 2013).

As social constructionism forms the ontological basis of this piece of research, supported by a phenomenological and interpretive approach, the research method aimed at is qualitative in nature as the principal purpose this study is to explore information on a deeper level, to understand the participants' experiences. Furthermore, this method allows the researcher to reconstruct and interpret "*the way individuals and groups organise their interpretations including the way they attach meaning to behaviour*" (Miller & Holstein, 1993, p.54).

From this perspective, it can be said that there is no single reality, rather there are multiple realties relative to context and thus, expressed meanings are a valid form of knowledge and in this research best represented by an inductive approach that includes sensitive and open-ended questioning (Bailey, 1997; Hill-Bailey, 1997).

The following Table 6, gives a summary of the phenomenological approach applied in this research.

Summary of Phenomenology	
Defining Features	- Focuses on subjective human experience - Analysis is generally thematic in nature - Used more often in social and health sciences
Epistemological Leaning	- Interpretive - Subjective meaning is interpreted and extrapolated from discourse - Inductive analysis
Strengths	- Ideal for smaller data sets - Data explored more deeply and extrapolated beyond the text
Limitations	- Focuses on human experience - May interpret too far beyond what's in the data - Not necessarily systematic
Key sources	- Giorgi (1970, 2009) - Moustakas (1999) - Smith, Flowers and Larkin (2009)

Table 6: Summary of Phenmenology

3.4 METHODOLOGY

This piece of research is set at employing qualitative research as the main methodological approach. Qualitative inquiry is mainly designed at understanding (Verstehen) how people attach meaning to the things they do (Guba & Lincoln, 1994). It is important to study people in their natural settings to achieve that understanding, thus, this inquiry is naturalistic and descriptive in essence, dealing with people's perspectives in an emic way.

The emic perspective (Harris, 1976) is taken when researchers attempt to examine the experiences, feelings and perceptions of the people they study. They "*uncover*" the meaning people give to their experiences and how they interpret them. Qualitative research is based on the premise that individuals are best placed to describe situations and feelings in their own words (Mack, 2005).

In the quest of seeking insider perspective and consequently the meanings that individuals attach to the things they think and do, researchers gain knowledge and insight into human beings. They are involved in detailed portrayals of the participants' experiences as they uncover feelings and the meanings of participants' actions. In-depth accounts are generated which present a lively picture of the participants' reality. This form of research is in tune with the nature of the phenomena examined, perceptions are quality experiences (Matlby, 2013).

Denzin (1989) defines this process as *thick description,* where detailed, contextual accounts of experiences and webs of social relationships are presented. Also, a central feature to interpreting social actions is to highlight the motivations and intentions for the said social actions (Ponterotto, 2006). The researcher further stresses the importance of context. He states that the discussion of a qualitative research report "*successfully merges the participants lived experiences with the interpretations of these experience*" (p.547). Lastly, thick interpretive work gives the readers an understanding of the reported social actions as well as credibility and resonance to the research within the research community, the wider audience of readers and the research participants (Ponterotto, 2006).

Moreover, qualitative inquiry is predominantly concerned with processes and not outcomes of a specific phenomenon; it is mainly interested in constructing knowledge and theories grounded on the data collected. Bogdan and Biklen (2012) state, "*you are constructing a picture that takes shape as you collect and examine the parts*" (p.6), in other words, this research method proceeds from collecting specific data to more general conclusions.

As qualitative research seeks to understand reality as it is seen by the participants; reality is dependent on the individual's perspective and findings are based on interpersonal transactions (Holstein & Gubrium, 2008). Researchers (Allen & Walker, 2000) highlight that more attention has been paid to qualitative inquiry in light of interpersonal communication topics, although in understanding doctor-patient communication, the use of quantitative methods still holds predominance.

As this research mainly focuses on understanding and reconstructing subjective perspectives of participants, the research subjects define concepts, terms and critical issues (Veal & Ticehurst, 2005). If such an understanding is presupposed, qualitative research methods are seen to be appropriate. Qualitative research aims at analysing words and images rather than numbers. It is a circular process of describing, connecting and classifying data (Dey, 1993).

This research aims at generating knowledge on women immigrants' and general practitioners' perceptions of medical encounters, furthermore, this research intends to understand the way culture is defined, constructed and negotiated by both participants through the communication practices. So, to attain the research purpose and objective, the qualitative research methodology can be defined as the most appropriate method.

3.5 RESEARCH SETTING

The setting for the interview is important, as interviews must be seen in the social context in which they occur; this affects the relationship between the researcher and research as well as the data generated by it (Manderson & Andajani-Sutjahjo, 2006).

As mentioned earlier in section 3.3, qualitative inquiry is naturalistic in nature. The natural environment plays an important role as individual behavior can be understood best where the activity takes place in context. As Kirk and Miller (1986) state that it is important as well as seen as a tradition in the field of social sciences that

people are observed in their environment where the interaction should also take place. Moreover, the interaction should be in people's language and on people's terms. Qualitative researchers also claim that the experiences of people and other phenomena are essentially context-bound i.e. they cannot be free from location and time (Matlby, 2013).

As the setting plays an important role in obtaining rich data, meetings have been arranged with participants where they feel most at ease. In the case of the general practitioners, schedules have been arranged at their practices and in the case of the women immigrants, meetings have been planned either at my office or at their residences. All meetings with the participants have been arranged on appointment only and at their convenience as well as at the venue of their choice.

A participant-centered perspective has been adopted such that the participants feel at ease and can talk freely as well as are not under much time pressure. The most important aspect remains to meet at a venue where participants could talk undisturbed. It is vital to create a congenial and friendly undisturbed atmosphere, on one hand, so that the participants can reflect, express their point of views and experiences, on the other hand, allow me - the researcher - access to the participants' world by listening carefully in this selected environment and through observation, so that I can gain insights into the problems as well as a deeper understanding of the participants with whom I interact.

3.6 RESEARCH METHOD

Qualitative research can be conducted in a variety of ways (Tesch, 1990). In broad terms structured, semi-structured interviews, focus group interviews, observations, ethnography and bibliographic research can be distinguished (Veal et al., 2005).

For the research questions, semi-structured in-depth interviews have been decided upon as the main source of data collection. Single- session interviews with a substantial number of participants are planned. The intent is to gain insight in dimensions of communication and the multi-faceted understandings of the meaning of culture in the communication process. That is to understand how meanings of culture are construed and negotiated in medical interactions between women immigrants and general practitioners.

According to Rubin and Rubin (1995) in-depth interviewing constitutes an excellent method for obtaining a deep understanding of the way "*individuals feel and think about their worlds*" (p.1). The goal of interviewing is to understand how a particular person thinks, behaves and feels. Lindlof (1995) believes that interviewing can provide the researcher with access to information about events that s/he could not otherwise observe. Holstein and Gubrium (1997) call it "*the rhetoric of interviewing*" as researchers gain full access to inner feelings and thoughts uncovering the private self, where the situation and behavior is also observed.

Interviewing is a two-way communication where the interviewer asks questions to the participant in that case the interviewee who responds to the questions and further questions often arise as a result It is a dialogue - a form of interaction. Rubin and Rubin (2005) believe that both researcher and informant become "*conversational partners*". According to them, interviews are more defined as it a conversation with a purpose and help to understand the participants as well as in exploring their perspectives and interpretations.

Since interviewing is a collaborative effort and an active process, I have decided to name my interviewees "*participants*" as the term participants expresses the collaboration between the researcher and the researched (DePoy & Gitlin, 2016) and the equality of their relationship. Terms such as interviewees, respondents, informants sound mechanistic and imply passivity, as it is a response to a stimulus in this case a response to the research questions.

Philosophers and historians such as Dilthey (1833 – 1911) say that the social sciences should emphasise emphatic understanding. In qualitative research, the voices of participants can be heard; feelings and experiences can be grasped. Rubin and Rubin (1995) argue that in order to create a dialogue and carry out in-depth interviews, the researcher needs "*to develop a strong empathy for the interviewees*" (p.12). They add that researchers using qualitative interviewing are not "*neutral, distant or emotionally uninvolved*" (p.12).

Miller and Boulton (2007) state that the relationship between participants is one of continuously shifting boundaries between the professional and the personal. It is, indeed, quite possible that towards the end of the research project, trust and friendship may generate as then it will be difficult for both interactants to extricate from it.

To be able to conduct good and successful interviews, it is very essential to develop a good interpersonal relationship between the researcher and his/her participants based on mutual respect, trust and equality. The interviewer respects the way participants develop and phrase their answers (Marshall & Rossman, 2015) as they are active participants in a social encounter.

Trust builds up in the involvement and interest in the perspectives of the respondent. The interviewer is not a blank screen (tabula rasa) but an active participant co-constructing meaning (Matlby, 2013). Rapport and trust make research more interesting for participants as they feel free to ask and to answer questions. One could say it is like a methodology of friendship. Hence, it is important to create a good rapport with the participants based on trust and openness such that the participants get actively involved and at the same time giving and creating the space for the participants to voice their opinions and thoughts.

Furthermore, the interviews will be conducted like a natural conversation where a set of open-ended questions contained in two respective interview guides for the two groups, focusing on the issues mentioned in the research questions. The sequencing of questions would perhaps vary for the participant, as it will depend on the

process of the interview and the responses of each individual. The interview guides serve to collect similar types of data from all participants.

Like in a natural conversation, questions have been rephrased to clarify meaning; prompts or probing questions used to search for elaboration, meaning or reasons. Seidmann (2006) suggests the term "*explore*." Just to cite some examples exploratory questions are also planned to elicit further information. *What was the experience like for you? How did you feel about that? Can you tell me more about that?* Nonverbal prompts such as eye contact, nodding, or leaning forward are very useful, they, on one hand, reduce anxiety for the interviewer and participant and, on the other hand, encourage the participant to reflect and talk more.

Moreover, the researcher's good listening skills are also asked for, as s/he needs to be active, responsive and react as a flexible listener to what the interviewee is saying. The interview agenda, thus, should be flexible to allow "*participants to shape content of the interview*" (Bogdan & Biklen, 1998, p.4). The listener who is the researcher is the learner and the informant is the teacher (Matlby, 2013). So, it is important to listen carefully and ask relevant questions to gain insights into problems and a deeper understanding of the people with whom the researcher interacts.

Responsiveness is vital as interviewing may affect participants who do not just reveal their experiences and deep thoughts to the researcher but also might become aware of hidden feelings for the first time, which might provoke distressing memories and strong emotions and the researcher should be prepared to allow the participant to work through this (Butler, Copnell & Hall, 2018).

In addition, the interviews will be audio-recorded as well as note-taking during and after the interview is recommended. An approximate length of time should be agreed upon. The general time for interviewing varies between half an hour to a maximum of three hours (Matlby, 2013). For this study I have planned interviewing sessions between half an hour to an hour, this will naturally vary depending on the interest and willingness of the participants to uncover their experiences, feelings and thoughts.

As participants explore and express their thoughts, they tend to exert more control over the interview as their ideas have priority. The participants have more power because they can guide the researcher to issues that are of concern to them. However, the researcher should not overlook the issues s/he wants to have covered in the interview (Altman, 1995).

All in all, it can be said that to get an accurate and true picture of the respondents' themselves and their lives, all these aforementioned aspects are important and must be taken into account particularly in single-session interviews to overcome biases such as the tendency of participants to give safe, simple answers, to downplay issues, etc. associated with one-off interviews (Read, 2018). Moreover, interviews are interactional encounters as they involve interaction and relation and the social dynamics that emerge in the interview shape the nature of the knowledge generated.

3.7 SAMPLING STRATEGY, SIZE AND DESIGN

3.7.1 Sampling Strategy

Sampling is an important part of the research procedure and must be suiTable for the specific research topic and research question. Researchers distinguish between the target population, the study population and the sampling frame (Proctor & Allan, 2006). The target population is the accessible population that has the knowledge of the phenomenon which a researcher is seeking to explore. The study population are those the researcher can gain access to and the sampling frame is the sample that is chosen.

Sampling is concerned with selecting individuals who are likely to be able to inform the development of the study while ensuring that the sample includes a representative group of the phenomena under study (Matlby, 2013). The process of sampling is driven by the principle of "*theoretical sampling*" (Chenitz & Swanson, 1986), where data should be collected to generate theory for which, cycles of collecting, coding and analysing data need to be undertaken. The theoretical sampling indicates what data to collect and from whom.

Qualitative research is often alleged to be anecdotal (Bryman, 1988; Silvermann, 1989). One reason for this viewpoint is the frequent use of relatively small samples including subjectively selected and biased research subjects, which happen to fit the researcher's argument (Have, 2004).

However, as qualitative research aims at understanding a phenomenon rather than finding out statistical inferences, a purposive sample of interviewees is appropriate (Veal, 2005). Participants should be carefully selected in that they have the potential to contribute rich information. A purposive sampling strategy will be primarily implemented because the participants chosen specifically with this strategy tend to share commonalities that will be explored.

Moreover, the selection of participants is criterion-based i.e. certain criteria are applied and the sample is chosen accordingly. The term purposive is valid as they are selected for a definite purpose, hence, the group is specified in advance. Purposive sampling or criterion-based sampling as it is also termed by (Endacott & Botti, 2007) is based on the judgment of the researcher.

Patton (2002) gives a whole range of sampling types, such as heterogeneous sampling, chain referral or snowball sampling, convenience or opportunities sampling. The first two sampling types have also been employed in this piece of research.

Heterogeneous sampling is where the participants selected for the research in the group women immigrants differ from each other in their ethnicity and nationality. In the group general practitioners, the national background of the participants is the same, however, heterogeneity is given in their gender. 5 male and 3 female doctors have been selected. Chain referral or snowball sampling as termed by Biernacki and Waldorf (1981) where a participant is asked to identify potential participants with knowledge of that particular topic of investigation and they continue to nominate other individuals for research.

When a certain group of members of a particular population is identified and the sampling frame is set, boundaries are automatically created between those who are included in the study and those who are excluded from the study. In this manner, the inclusion and exclusion criteria are applied. Voluntary participation is an important aspect of inclusion.

3.7.2 Sample Size

The sample size can be small or large. It is often remarked that about 14 – 20 participants are in general required in a heterogeneous group (Matlby, 2013). The size, however, does not determine the quality of the data nor the importance of the study. An overlarge sample might not capture the meanings participants ascribe to their experiences and could result in the loss of the unique and the specific (Pinzon-Perez, Perez, Torres & Krenz, 2005). As regards my research, the sampling size has not been defined in advance, the sampling will be discontinued, when I determine that the point of saturation has now been reached.

Saturation indicates that everything of importance to the research project will emerge in the data and concepts obtained. Guba and Lincoln (1985) call it "*informational redundancy*" (p.202). Informational redundancy denotes that no new concepts or dimensions for categories can be identified which are important for the study. This does not mean that nothing can be found at all. Boyle (1994) argues that although no specific rules or guides exist on saturation, frequency, quantity and repetition of ideas in the data do not signify saturation nor data adequacy. It is for the researchers themselves to decide when this has occurred.

3.7.3 Sampling Design

Sampling should be both appropriate and adequate (Morse & Field, 1996). Appropriateness means that the method of sampling fits the aims of the study and helps in understanding the research problem. Adequate is the sampling strategy when it generates sufficient information and quality data. By implementing the purposeful sampling strategy -

heterogeneous sampling mentioned above in section 3.7.1 in which the women immigrants originated from different countries, in the case of general practitioners, heterogeneity has been brought about in the well-balanced mix of male and female doctors.

The appropriateness and adequacy are also explained in section 1.3 as to why specifically women immigrants have been selected. To list them briefly again, they are considered as "*dependent persons*" when they immigrate; they face a higher risk of social exclusion and isolation as well as in view higher physical and mental distress; the researcher can identify herself better with this group.

Furthermore, the location of the doctors has also been of importance. Most of them are located in Innsbruck and two in peripheral cities – in areas where they have a large number of mixed populations as patients. In this manner, both appropriateness and adequacy have been striven for concerning both groups of participants in my study.

As the distinct focus of the research is on the communication between women immigrants and doctors from the majority ethnic culture, the participants in this investigation had to meet some threshold criteria for inclusion:

Women Immigrants

- Participants originating from a different ethnic group or nationality.
- Participants are only women.
- Participants who have moved to Austria from their home country – (first generation).
- Participants are recent immigrants i.e. residing in Austria for 10 and less than 10 years.
- Participants who speak German or English fluently.

Doctors

- Participants who belong to the majority ethnic group.
- Participants may be male or female.

- Participants born and raised in Austria.
- Participants who have their practices in Innsbruck or its surroundings.
- Participants who have their practices in areas where a large heterogeneous population resides.
- Participants who are general practitioners.

The exclusion criterion will apply to women immigrants who do not speak enough German nor English and require interpreter services during medical encounters. This is because information may get lost during interpretation and hence, such participants will not be considered. On the other hand, doctors who may belong to an ethnic minority group but are born and raised in Austria will also be excluded as they are often defined as dual identities (Verkuyten & Thijs, 2010). Dual labels define ethnic minority members as part of their ethnic minority groups as well as members of the superordinate national category. Thus, to avoid this complexity, ethnic minority doctors have been left out in this study. It would certainly be of interest to include them in future research.

Regarding gender aspects, the researcher intends to leave out men immigrants as then literature on gender must be studied and included. This would make the research more complex in nature.

The study will be carried out in Innsbruck, Austria. Moreover, to cope with time constraints and practicality aspects, participants chosen will be mainly based close to the researcher's professional and residential location. Participants will be carefully selected from different minority groups as this study aims to gain insight into different perspectives that influence the communication process.

Finally, the sample size has not been predetermined. Guba and Lincoln (1985) suggest that an appropriate number of respondents depends on consideration of expected information. In my research, when in the investigation a point of redundancy is reached, where further participants will not contribute any new information, then sampling will be terminated.

3.8 RESEARCH QUALITY AND RIGOUR

Quality characteristics in qualitative research vary considerably from those in quantitative investigations. Nevertheless, qualitative approaches have to comply with relevant goodness criteria. These are mainly based on aspects like trustworthiness and authenticity (Guba & Lincoln, 1994).

As the research questions in this piece of research seek understanding, the richness of the data collected is considered to be more important than the generalisability and replicability of the study. Since the interviews mainly depend on particular interactions between the participants and the researcher, it would seem to be difficult to repeat these interactions precisely. Furthermore, detailed replication of this study is impossible because the research relationship, history and location of participants will differ from study to study.

As a purposive sampling design will be chosen, which is considered as an appropriate sampling strategy, the interview participants will be selected such that they can contribute rich data. Furthermore, validity of the investigation can be assured to a certain degree by two means:

- An approach to comprehensive data treatment (Mehan, 1979).
- Appropriate tabulations (Hepburn & Potter, 2004; Silverman, 2006).

The first aspect, which will be discussed is reliability. In addition, the Thematic Analysis method (TA) used for data analysis has been explained in detail in chapter 5, indicating the extensive procedure undertaken for data treatment. The second aspect is that measuring quantities of certain aspects in participants' statements should influence interpretations. This appears to be a sufficient procedure because the frequency of distinct answers in participants' statements is seemingly of high relevance for the interpretations derived. The process of matrix query carried out for appropriate tabulations in chapter 5 as well as the various matrix queries on prominent themes. An excerpt can be found in section Appendices 21 and 22.

The aspect of reliability is problematic in qualitative research. The possibility of gaining the same results cannot be fully assured if the research procedure is carried out several times in the same way (Yin, 1994). The interrelations between participants and researcher are hard to be repeated by other persons because they depend on individual and situational characteristics.

However, reliability can be provided to a certain level through comprehensibility. For this, it is most important to be exact in the description and to record the whole research procedure. Thus, the investigation should be as comprehensible as possible. To secure high-quality research interviews, several means are suggested (Miles & Huberman, 1984; Silverman, 2006):

- A pre-test should be conducted to identify potential weaknesses of the approach.
- Training of the interviewer should prepare for the appropriate conduct of the sessions.
- Interview sessions should be audio recorded.
- Interviews should be carefully transcribed, preferably by the researcher.
- When reporting the findings, comprehensive interview data should be included to provide readers with an impression of the data collected.

In this piece of research, the following measures have been applied to comply with the various requirements:

- Two interview guides have been outlined, one in German and one in English.
- The interviews have been conducted taking the guides into account, however, the agenda was kept flexible.
- All interviews have been carried out only by the researcher herself.
- Participants have been provided with an information sheet and consent form before the interview sessions; the consent form was signed at times

at the beginning of the session but in most cases at the end of the interview.

- Interviews have been audio recorded.
- Interviews, when held in German, have been translated by the researcher herself; reviewed by an Austrian colleague who works in the field of health care.
- Interviews have been fully transcribed by transcribers and they have signed a non-disclosure agreement as regards the confidentiality of the works.
- Transcribed interviews have been fully reviewed and checked for accuracy by the researcher herself.
- Interviewees received an interview transcript for approval only when they asked for it. This occurred in the case of women immigrants Maya and Dana (pseudonyms).
- The whole process of data treatment i.e. from data collection to analysis has been carried out by the researcher herself.

One key aspect to enable a sufficient degree of research quality is to carry out a pre-test to identify potential weaknesses (Mauch & Birch, 1989). I aimed to carry out a pre-test or pilot phase of interviews with the outlined set of open-ended interview questions with four women immigrants and three general practitioners. The pilot phase was crucial as it provided valuable advice for further improvement and marked the high level of achievement required.

Furthermore, maximum comprehensibility of the procedures by highlighting the relevance of the material derived through the interviews, as well as pinpointing the logic that connects this material to the analysis has been intended. In addition, I have aimed to facilitate transferability through these procedures as an extensive description may enable new research with other participants in a similar context.

The reflexivity of the researcher also plays an important role. Finlay (2002) names reflexivity as the process where researchers engage in explicit, self-aware

analysis of their role. According to Finlay (2002) it is a conscious acknowledgment of the researchers of their involvement in the research. It also includes the awareness of the interaction between the researcher and the participants, the research itself and they take into account how the process of the research affects findings and eventual outcomes.

Although the researchers are not at the forefront of the stud, they take a significant place in the process during collection and interpretation of data as well as in the relationship they have with both the participants and the readers of the research. Researchers' standpoints and values shape the research (Fontana & Frey, 2000).

In view of this research, I have written memos after each interview penning down my experiences during the interview. I have also written about my experiences as regards the reasons for this study, aims and objectives, the problems during data analysis or when reading and writing up my literature review and so on. An excerpt of my experiences at various stages of my research can be found in my reflective journal. See section Appendices 20.

I also aimed at including Finlay's (2003) five types of reflexivity in my research, namely: introspection, intersubjective reflection, mutual collaboration, social critique and discursive deconstruction. The process of introspection has already begun as mentioned above and has accompanied me throughout the study, in particular, more in detail from the time of planning and conducting interviews onwards. I tried my best to create a good rapport based on trust and openness with my participants as the relationship with my participants affects the research (intersubjective reflection), also making my participants feel comfortable in answering the questions and prompts which have resulted in the generation of rich data for analysis.

I concentrated a lot on achieving mutual collaboration as participants are part of the research and their reflections on it influence the context of the relationship, which, in turn, affects the process of the research. I tried to steer the interviews so that all the questions on the interview guide were asked and responded to, however, the agenda of

my interview guide was flexible as the questions were not asked sequentially, giving my participants the power to talk as much they wish on their experiences (social critique).

Lastly, the findings can have multiple meanings and indeed my focus here was on the construction of the text (discursive deconstruction). In this manner, I have attempted to give this piece of research a good research quality.

3.9 STRENGTHS AND LIMITATIONS

Like all other methods, interviewing has its strengths as well as its limitations. Atkinson and Silverman (1997) claim that through interviewing, researchers gain full access to inner feelings and thoughts uncovering the private self. They provide insight into the thoughts of the participants and their understanding of the phenomenon under investigation. Interviews allow an impression of the depth and breadth of the respondents' opinions to be gained. This enables the researcher to see the world from the participants' perspective (Fontana & Frey, 2000).

Another advantage of interviews is that not only are they about the topic raised by the researcher but they also reveal social interactions between interviewer and interviewee in this study and cultural contexts (Miller & Glassner, 2004). As situation and behavior is also observed, data is hence, collected on social action and interaction. Thus, observation, which is part of the process, is not only said to be complementary to interviewing but is also said to be a form of within.

The method of interviewing involves a lot of flexibility because the researcher can prompt and probe to derive more information as well as to clarify meanings of words unclear to the researcher. It also allows the participants to react honestly or spontaneously as well as to take time to reflect on the questions posed and articulate slowly in reply. Nevertheless, it is not known with certainty, if participants are telling the truth or if their memories are faulty. However, it is still the truth as seen from their

perspective even though it is selective. The motivations and thoughts are more important than faulty data (Holloway & Freshwater, 2009).

On the other hand, the downsides of interviews must also be taken into account (Yin, 1994). Researchers' bias might influence respondents' answers. They also have their perception under study (Matlby, 2013). Creswell and Plano (2007) warn against the possibility of misinterpreting the words of the participant. Consequently, results would become questionable.

Honest statements can only be expected when participants trust the confidentiality of the research process. To develop trust a lot of time is required, which the researcher may not always have, particularly in single-session interviews. Sometimes, it may be difficult to develop trust with the participants as they may not long to have a good relationship with the researcher. It is also possible that participants may modify their answers to please or to appear positive to the researcher. To minimise this effect, I tried to spend much time developing trust with the participants by engaging in small talk, active listening, etc.

Furthermore, subjectivity is an important aspect, which also serves as a limitation to some extent in this piece of research. Bracketing, for instance, is a component of our attitude in which we consciously identify our values and biases that influence our assumptions about doctors or patients (Greenfield et. al., 2010). To control or check my biases, the process of intra-reliability has been applied during the thematic analysis method.

Participant selection bias is also a limitation as only interested participants, who have the time and fulfill the requirements, are chosen for an interview. It is quite possible, that those participants who do not have sufficient time nor are interested in participating may have different perceptions and experiences to report.

Lastly, translation of transcripts from German to English must be factored in this research. Loss of information in the translation process could occur or information

may not be correctly interpreted, too. Thus, to prevent loss of information and misinterpretation, I had a colleague look into the translations.

3.10 ETHICAL MINDFULNESS

Research ethics is an important issue, which has to be reflected upon prior to any investigation. This research has been conducted in full accordance with all mandatory requirements of Edinburgh Napier University and its policies. In addition, the required regional ethical consents from the Chamber of Doctors in Innsbruck, Austria as well as from the Regional Health Insurance (Tiroler Gebietskrankenkasse – TGKK) have been obtained. Apart from committee approvals, research ethics is an obvious necessity for every researcher whose scientific interest is relating to personal questions.

The legal procedures and protocols have been strictly followed throughout the study. When individuals agreed to participate, they received an information sheet and the consent form before the interview. The information sheet briefly informs participants about the aim and purpose of the intended investigation.

Although the interviews took place in a German-speaking environment, all participants have been provided with the English version of the information sheet and the consent form. This did not pose any problems at all. All participants were also shown the ethical consents granted by the various authorities. The regional ethical consents, which are in German, have been translated into English, too. See section Appendices 3 to 6.

Before starting the interview, the details on the information sheet were repeated. Participants were encouraged to ask questions about the aim, purpose and procedure of the investigation. Subsequently, participants signed the consent form a prerequisite and requirement for participation. See section Appendices 1 and 2.

The sessions have been recorded followed by their transcription. Participants were told they could receive a copy of their transcriptions if they wished. They were also asked if they could be contacted for clarifications if needed. Fortunately, this was not required. However, two women immigrants Maya and Dana (pseudonyms) received their transcripts on request for approval.

The general practitioners are keen on a summary of this thesis, which will be sent to them when officially permitted by the university. To safeguard the participants' rights, some issues that I as a researcher have addressed in the consent form are outlined below:

- Autonomy -participation in the interview is voluntary and participants can withdraw at any time of the study; participants will not face any compulsion to answer all questions asked.
- Adults only are included in the study.
- Participants are encouraged to ask questions at any time of the research procedure.
- Confidentiality and privacy of data is assured to participants.
- Beneficence – this study is based on the requirement to benefit the participant; no harm or malfeasance will come to the individual due to participation. There is neither physical nor emotional harm to the individual when their general experiences are recorded by the researcher.
- Justice - the principle is concerned with fairness – the needs of the participants comes first before the objectives of the research – the participants are not coerced or may feel obliged to take part in a research study by virtue of a probable pre-existing relationship.

The information collected has been safely stored on my laptop and two external hard drives. Their security has been ensured such that they are first saved in a password-protected computer file; each participant has an alphanumeric code, thus, no names or full names are disclosed respecting the confidentiality and anonymity of the participants; the data has been used in a responsible manner i.e. the transcribers, as well as my colleague who looked into the translations, received only the alphanumeric codes

of the participants. Furthermore, all participants have been given pseudonyms when quoting them in chapters 6 and 7, hence, not making them identifiable when giving background information about that person.

3.11 SUMMARY OF CHAPTER THREE

This chapter deals with the methodological approach and the choice of qualitative inquiry. Based on the paradigm of social constructionism, the methodological approach adopted is phenomenological and interpretive in nature. Since a specific phenomenon is being researched where the lifeworld of the participants is being explored, this is the most appropriate approach for this piece of study.

The research aims to gain an in-depth understanding of ways individuals construct meaning through their communicative actions – that is to understand how meanings of culture are construed and negotiated in medical interactions between women immigrants and general practitioners.

To explicate meaning from the investigations, in-depth, interviews have been carried out. The interview guides created for the two groups of participants contain open-ended questions so that the participants talk about their experience in the consultation process as well as encouraging them to ascribe meaning to obtain rich data in the single-session interviews.

Furthermore, active listening and establishing a climate of mutual trust in order to build a good rapport with the participants are important aspects to be borne in mind to approximate a genuine interaction between me - the researcher and the participants.

In addition, the natural research setting is chosen by the participants, purpose sampling strategy, the not-pre-defined size but determined through the point of saturation and sample design with inclusion and exclusion criteria also play an important role and add value to the research.

The quality of the research conducted is of underlying importance. As this research concentrates on deriving in-depth knowledge in interpreting and understanding how people live their experiences and make sense of their actions and not on theory testing, it will not be appropriate for generalising. The comprehensibility, transferability and reflexivity approach, as well as their pursuits, have contributed to the quality of the study. Lastly, the study has been carried out following the prescribed ethical rules and regulations of my university.

4 Chapter Four Data Collection

4.1 INTRODUCTION

This chapter describes the methods used in collecting data for the study such as the interview guide, the scheduling of interviews for the pilot and main phase, the conducting of interviews, subsequently the planned thematic analysis for the analysis of the data gathered and the issues regarding the evaluative rigour and ethical considerations.

Based on the research design which is qualitative in nature and the literature review as well as the research question, an interview guide was drawn up. The interview guide contains questions for the research participants. The interview questions varied slightly for both groups. The questions were mainly open-ended so that I could elicit in-depth information from my respondents. See section Appendices 7 and 8.

4.2 INTERVIEW PLANNING

Interviews are "*essentially contextually situated social interactions*" (Murphy, Dingwall, Greatbatch, Parker & Watson, 1998, p.120). It is a social occasion where the information given by the respondents are closely attuned to the local context and is, indeed, socially constructed and reflects the particularities of the context (Briggs, 1986; Mishler, 1986; Silverman, 1973). Interviews are a conversational interaction which, however, must be planned and prepared for. The questions are partially prepared for and it is the role of the interviewer to improvise on them spontaneously. The main aim is to go "*in-depth*" to get more detailed knowledge of the issue (Wengraf, 2001).

Semi-structured in-depth interviews containing open-ended questions were planned and chosen as in this process of co-present interaction in the face-to-face meeting of both participants – the interviewer and the interviewee participate in the

process of understanding. Witzel (2000) considers this process as an interplay between induction and deduction. Subjective narrations of issues are initiated in an interview by guided and theory-driven questions that are then complemented by dialogues, in which the interview partners try to establish common ground and mutual understanding.

Moreover, interviewing is an irremediably intersubjective enterprise as it begins with common sense perceptions, explanations and understandings of some lived cultural experiences and aims to explore the contextual boundaries of that experience or perception, to uncover what is usually hidden from ordinary view or reflection or to penetrate to more reflective understandings about the nature of that experience (Johnson, 2011).

In this respect, the aim of using interviewing is to understand and learn the phenomenon of how my participants see the communication process in a medical encounter and to explore if any cultural elements play a role in this process and this process of exploration has been supported with the interview guides.

4.2.1 Interview Guide

An interview guide, which is a script that structures the course of the interview, has been prepared (Kvale, 2007). The questions outlined in the interview guides are based on the research questions. Two interview guides have been prepared. Almost all the questions are identical with just a minimal difference. The two interview guides illustrated below show how the thematic research questions have been translated into interview questions aiming to produce, on the one hand, thematic knowledge, and on the other hand, to contribute dynamically to a natural conversational flow for spontaneous descriptions of the respondents' lived world.

Research Questions and Interview Questions for Women Immigrants

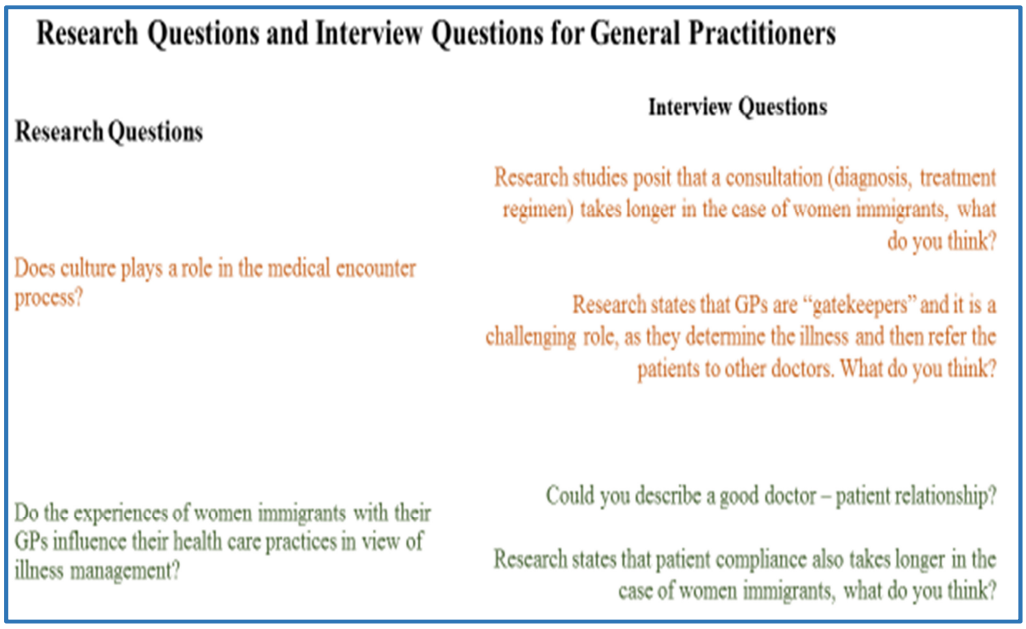
Research Questions	Interview Questions
Does culture plays a role in the medical encounter process?	Do you feel that the interaction with your GP here is different from the ones you experienced when you were in your country of origin? In what way?
	What were/are your expectations in a medical encounter?
Which dimensions impact the communication process?	Describe your experience of a recent consultation with a GP?
	Can you describe some recent consultations in which you encountered difficulties?
	What do you think caused the difficulties? How could they be avoided?
Do the experiences of women immigrants with their GPs influence their health care practices in view of illness management?	Do you think your relationship with your doctor is closer/better now than it was at the beginning? Why?

Figure 5: Research and Interview Questions for Women Immigrants

Research Questions and Interview Questions for General Practitioners

Research Questions	Interview Questions
Which dimensions impact the communication process?	Could you pleae describe a consultation process in view of women immigrants?
	Could you describe any communication difficulties encountered in your consultation?
	What strategies do you use to communicate with patients when you face comprehension problems? Do they differ from patient to patient
	Or
	What do you do to overcome those communication barriers?
	What is a successful interaction for you?

Figure 6: Research and Interview Questions for General Practitioners



Research Questions and Interview Questions for General Practitioners

Research Questions	Interview Questions
Does culture plays a role in the medical encounter process?	Research studies posit that a consultation (diagnosis, treatment regimen) takes longer in the case of women immigrants, what do you think? Research states that GPs are "gatekeepers" and it is a challenging role, as they determine the illness and then refer the patients to other doctors. What do you think?
Do the experiences of women immigrants with their GPs influence their health care practices in view of illness management?	Could you describe a good doctor – patient relationship? Research states that patient compliance also takes longer in the case of women immigrants, what do you think?

Figure 7: Research and Interview Questions for General Practitioners

The more spontaneous the questions and the interview procedures are, the more probable is it to obtain spontaneous, vivid and unexpected answers from the respondents (Kvale, 2007). The questions in the interview guide appear in a descriptive form to elicit deeper and spontaneous responses from the respondents rather than any speculative explanations of why something took place.

Spradley (1979) has presented some introductory interviewing procedures that he refers categorically to as "*grand-tour*" and the "*mini-tour*." A grand-tour question is one that asks for a description of a place, in the case of this research, they are questions as follows:

- "*Could you describe a consultation process with a GP?"*
- *"Could you please describe a consultation process in view of women immigrants?"*
- *"Could you describe a good doctor-patient relationship?"*

Asking such grand-tour questions also put the participants at ease and help in creating an interviewer-interviewee relationship.

The mini-tour question is also a similar type of information gathering however, it concentrates on a smaller area of activity such as a specific part (Johnson, 2011). In relation to this research, these questions are, namely:

- "*What do you think caused those difficulties? How could they be avoided?"*
- *"What do you do to overcome those communication barriers?"*
- *"What is a successful interaction for you?"*

The interview guides were prepared and the interview questions kept intentionally brief and simple, easy to understand for the respondents. The interview guide contains introductory remarks, introductory questions like "*Can you describe a recent consultation with your GP?*" to get spontaneous rich descriptions of the participants' lived experiences. In addition to the grand-tour and mini-tour questions that were asked and illustrated in Figure 5-Figure 7, the follow-up questions in the pilot phase were partly leading questions, which were unfortunately too specific as explained later in section 4.3.1.

Agreement to the statements made by the participants or encouragement to participants to continue with their talk has been predominantly expressed with non-verbal gestures such as nods or words like "*Hmm, Ahha, I see, right"* as seen in all transcripts. The probing questions stated in the interview guide *"You mentioned…, can you tell me more about what you meant?"*, intended to pursue further answers by probing the content without stating what dimensions are to be considered. See section Appendices 7 and 8.

The interview sessions were planned in such a manner that they lasted at least half an hour or more. The first few minutes were planned for seating arrangements and for the warm-up session i.e. small talk to break the ice, as well as brief information on the research topic and the consent form; the next 30 – 40 minutes for the interview, the final 5 to 10 minutes in closing the talk as well as in completing the formalities such as signing and countersigning the consent form.

At the end of the interview, when the participants left, I made a note of the interview session of my experiences with the interviewee such as the interviewee's facial and bodily expressions, the atmosphere during the interview, the enthusiasm of the participant. Next, these notes were transferred into memos and stored in my folder "*Recordings*" on my computer, on my external hard drive and in the quality data analysis (QDA) package NVivo, which has solely been used in the coding process and the graphic illustration of the themes and analyses.

4.3 PILOT PHASE

Research quality and rigour are important aspects of this study so for a novice researcher, who was learning the ropes of interviewing in this context, it was important to conduct the pilot phase to determine potential weaknesses and, in turn, to revise the open-ended questions or my interview techniques. The first step in this pilot phase was to contact the participants. The initial interviews were conducted with women immigrants. I approached a colleague to start with, who complied with the criteria. The other three were either spouses or friends of colleagues or personal friends, so it was quite easy to contact the respective participants and arrange appointments with them. Except for WI_01, who was interviewed at my institution, during the day, all the other participants were interviewed in the evening at their homes.

At my institution, I reserved a room for interview purposes. It was well illuminated and quiet, and there was ample time for me to test the recorder prior to the interview. WI_02 is coincidently a neighbour of a friend and was, in turn, interviewed in the evening at my friend's place. The interview was carried out in the living room where we were by ourselves undisturbed. In the case of WI_03 and WI_04, the interviews took place in the evening too, in their kitchen or living room respectively. Their children were around so there was some distraction that we had to take into account.

All interviews started with a small talk followed by a brief session on the purpose of this research and the formalities regarding informed consent were explained.

The consent forms were signed at the end of the interview. A copy was given to the respondents and I have one for my records.

Two interviews were carried out in English and two in German. Here again, except for WI_01, all the other respondents are not English natives. Table 7 lists their demographic details.

Name	Residence	Living in Austria since	Pseudonym	Profession	Duration of Interview	Language	Nationality
WI_IR_01	Innsbruck	2010	Isha	Research Assistant	38:17 minutes	English	Canadian
WI_NZ_02	Hall in Tirol	2014	Marina	Quality Manager	41:23 minutes	English	Ukrainian
WI_IM_03	Innsbruck	2010	Carla	Psychologist	30:01 minutes	German	Spanish
WI_EM_04	Innsbruck	2012	Emma	Architect	19:22 minutes	German	English

Table 7: Interview Duration & Demographic Details of Women Immigrants-Pilot Phase

As regards the second group - the general practitioners, I contacted my friends for recommendations as well as my new general practitioner to seek her interview. All appointments were made at the respondents' convenience. GP_01 and GP_03 are contacts I got through my friends. GP_02, on the other hand, has recently taken over my former general practitioner's practice, so I visited her in person and asked her if she wished to participate in the study.

All three general practitioners have their practices in Innsbruck or on the periphery of Innsbruck. The interviews were held in two cases at their practices, one early in the morning (GP_01) one at noon (GP_03) and one at the end of their daily professional activities. GP_02 came to my office where a room was reserved for interview purposes. This interview was held early afternoon.

Although all general practitioners said they spoke and could read and write well in English, they preferred to have their interviews held in German. Thus, all general practitioners' interviews were held in German. The recordings have been transcribed in German and then translated into English.

The same procedure was carried out in the case of women immigrants. At the beginning of each interview, after some chit chat, I explained the informed consent form, the purpose of the study, showed them the ethical consent received by the local authorities. The informed consent forms were signed at the end of the interview, a copy was given to the participants and one kept for my records. Details on the participants are summed up in the following Table 8.

Name	Gender	Pseudonym	Location	Profession for	Duration of Interview	Language	Nationality
GP_SM_01	Female	Melanie	Innsbruck	9 months	20:12 minutes	German	Austrian
GP_UG_02	Female	Susanne	Innsbruck	34 years	01:18:50 one hour and minutes	German	Austrian
GP_SP_03	Female	Lara	Rum – Innsbruck periphery	9 months	34:00 minutes	German	Austrian

Table 8: Interview Duration & Demographic Details of General Practitioners-Pilot Phase

4.3.1 Interviews in the Pilot Phase

In total, seven interviews - three general practitioners and four women immigrants were interviewed over a period of six months in summer 2017. All interviews are audio recorded and then saved in a separate folder on the computer for transcription. The archival logs created for both groups give information on all the respondents at a glance. Transcription protocols and memos have been created for each respondent.

The first question was always an introductory question based generally on the consultation process for both groups i.e. *"Describe the consultation process with your GP?"* or *"What does a general consultation process look like?"* This was intended to get

the ball rolling so to speak and then to gradually move onto the other questions in the interview guide. However, I must say that when I asked the general practitioners the question *"Could you please describe a consultation process in view of women immigrants?"* I did not specifically ask those participants what the term *"women immigrants"* conjured in their minds or how did they know when a woman is an immigrant. Based on the data, I can say that they predominantly assumed that one is an immigrant based on the person's German proficiency.

Conducting interviews for the first time was challenging for me and I displayed some nervousness and uncertainty. I was admittedly overwhelmed in this initial phase trying to listen attentively and trying to make a note of important statements and simultaneously formulating further probing questions. The interviews in German were undoubtedly more challenging than the English ones, as I had to listen to them and simultaneously formulate the probing questions or prepare for the next question to be asked in German despite having rehearsed the questions in the interview guide well in advance.

According to Dillon (1990) double attention must be given by the interviewer throughout the interview. This means listening to the responses to understand what the respondent is saying and at the same time ensuring that all the envisaged questions are answered within the scheduled time and at the level of depth and detail required for the study. Listening attentively to what is being said, at the same time managing the time such that it does not run out; and the direction and level of talk to get the interview material required, was strenuous for me in the pilot phase.

As mentioned earlier, it was initially not a very easy task for me to execute all these aforementioned interviewing techniques, as a result, there were too many probing questions asked, some which were not directly connected to the research questions. The probing questions did not comply with the kind of probing questions cited in the initial interview guide. They were, unfortunately, more specific and did not serve the objective of these interviews. Thus, the interviews of those four participants have not been

included in the analysis. These four excluded interviews have been highlighted in red in Table 7 and Table 8.

The interviews were transcribed in the respective languages. Each respondent was given an alphanumeric code and a pseudonym. The alphanumeric code serves to archive and retrieve their data and the pseudonym is used in the analysis. The general practitioners have been coded GP_01, GP_02, etc. The women immigrants were given the codes WI_01, WI_02, etc. to identify their data as well as pseudonyms in the research. The pseudonyms were selected in such a manner that the pseudonyms given to the general practitioners were mainly German, whereas the names given to the women immigrant varied. Pseudonyms were used to keep a sense of the human participant and to keep the respondents unidentified.

Transcriptions are a graphic representation of selective aspects of speaking and one or more person's behaviour (O'Connell & Kowal, 1995). All transcripts are kept verbatim without omitting the hesitations, gaps, inconsequentialities, etc. so that the interviews can be adequately analysed as communicative interactions. The change of "*tack*" in mid-sentence which denotes the change in the mind of the speaker be it the interviewer or the interviewee, the difficulties in formulating sentences or not answering questions efficiently or briefly, all these are valuable clues on the state of mind and feelings of the respondent (Poirier, Clark, Cerhan, Pruthi, Geda & Dale, 2004).

The seven transcribed interviews were analysed and details on the coding procedure and thematic analysis are explained in the following chapter 5 on data analysis. There were several mistakes made in the asking of questions such as too many questions were asked in one probing questions, for example:

- "*So, what do you think docs could do? It is interesting that these differences are there and doctors do not see them. Would you like to elaborate on that? What's your take on it?"*

- *"What did you do so that the patients overcome their fear? More assurance, more attention? How did you or did you use different strategies?"*

Furthermore, questions, which were not related to the topic, were unintentionally asked, for instance:

- *"Do you think the number of years of stay of women immigrants in Austria plays a role? The longer the stay the better the interaction?"*
- *"Do you think culture plays a role or is it solely language?"*
- *"Do you think it's a cultural thing? It's a cultural difference that you feel in the communication that you have, again when you compare it with back home?"*

This was in the case of four interviews. Two interviews with women immigrants WI_IM_03 and WI_EM_04 and two with general practitioners GP_SM_01 and GP_SP_03. As these questions were too specific and leading, and could also be seen, as indirectly misleading the respondents and not encouraging impromptu answers, the reliability of the interviews would have been reduced through the indirect influence on the interviewee's answers to further questions. Thus, those four interviews highlighted in red in Table 7 and Table 8 have been excluded from the data analysis since they did not correspond to the objective of my research. Hence, I can say that the pilot phase was an important learning process for me as I learned from these mistakes.

4.4 INTERVIEWS IN THE MAIN PHASE

Within the following four months i.e. from October 2017 – February 2018, a further 18 interviews were carried out - seven general practitioners and eleven women immigrants constituted this set of interviews. With the inclusion of only three out of seven interviews conducted in the pilot phase, a total of 21 interviews were conducted with eight general practitioners and thirteen women immigrants. Most of the women immigrants (7) were interviewed at their residences. Three were interviewed at my

office and one interview was held at the respondent's workplace. The interviews took place at different hours of the day at the participants' convenience.

With the exception of one, all the interviews were held in English. This exception was made as this respondent did not feel very confident in speaking English in situ. The interviewees were acquired through snowball sampling. Adverts posted on Facebook and websites of organisations such as Karibu – an organisation for foreigners living in the Tirol, resulted in no response. Thus, the best way of connecting with women immigrants was through recommendations and participant contacts.

The following Table 9 illustrates the demographic and interview details of the participants. They have all been given alphanumeric codes in chronological order and consecutively numbered as well as given pseudonyms. Despite the deletion of interviews in the pilot phase, the chronological numbering remains unaffected.

Name	Residence	Living in Austria	Pseudonym	Profession	Duration of Interview	Language	Nationality
WI_JW_05	Innsbruck	2015	Ramona	Architect	35:40 minutes	English	Russian
WI_BDL_06	Innsbruck	2011	Dana	Part-time lecturer	29:01 minutes	English	American
WI_EHD_07	Innsbruck	2012	Alia	Social Worker	29:49 minutes	German	Venezuelan
WI_AI_08	Innsbruck	2015	Maya	Part-time student and cashier	26:11 minutes	English	Indian
WI_KF_09	Innsbruck	2015	Linda	Lecturer	27:52 minutes	English	American
WI_LC_10	Innsbruck	2015	Lara	IT Specialist	28:15 minutes	English	Kenyan
WI_TT_11	Innsbruck	2013	Tamara	Logistics Assistant	23:21 minutes	English	Finnish
WI_IZ_12	Innsbruck	2017	Letizia	Senior Lecturer	19:49 minutes	English	Egyptian
WI_PGN_13	Innsbruck	2008	Samantha	Sales Specialist	24:36 minutes	English	Brazilian
WI_SF_14	Innsbruck	2008	Prisca	Lecturer	41:07 minutes	English	Bahamas
WI_CM_15	Innsbruck	2013	Irene	Sports Manager	13:33 minutes	English	Czech

Table 9: Interview Duration & Demographic Details of Women Immigrants-Main Phase

The interview guide was followed, probing questions were asked too; the only additional question, that was occasionally asked to the women immigrants in context, and to clarify certain statements made by them was, *"What kind of communication strategies you use to reach out to your GP?"*

The second group of general practitioners was also acquired through chain referral and via e-mail. I sent out about 10 emails to which four general practitioners responded positively and agreed to participate. Participants from the surrounding areas of Innsbruck such as Zirl and Arzl as well as from Schwaz were also contacted as these locations have a concentrated population of immigrants, too. Three out of seven doctors come from these surrounding areas.

These interviews were held in their language of preference German and they were held at their practices after working hours or around noon. In two cases (GP_08 and GP_09) interviews were held in the evening. The interview situation can be described as symmetrical – even with doctors. The participants were friendly and cooperative, and a good rapport was created. The interview guide was also adhered to. Probing questions were asked to all participants to elicit further clarification or more details. The following Table 10 illustrates the demographic and interview details of the participants

Name	Gender	Pseudonym	Location	Profession since	Duration of Interview	Language	Nationality
GP_AHK_04	Male	Martin	Schwaz	2007	33:03 minutes	German	Austrian
GP_MW_05	Male	Hermann	Zirl	1984	21:28 minutes	German	Austrian
GP_CO_06	Male	Michael	Arzl- periphery Innsbruck	2016	24:44 minutes	German	Austrian
GP_AW_07	Male	Matthias	Innsbruck	1981	27:00 minutes	German	Austrian
GP_CR_08	Male	Sebastian	Innsbruck	1983	42:41 minutes	German	Austrian
GP_GQ_09	Female	Jacqueline	Innsbruck	2000	17:51 minutes	German	Austrian
GP_MW_10	Female	Marlies	Innsbruck	2013	23:05 minutes	German	Austrian

Table 10: Interview Duration & Demographic Details of General Practitioners – Main Phase

Schatzman and Strauss (1973) have four types of follow-up question differentiated by function, the first two relating to events and the second two to coherence:

- Chronology (and then? when was that?')
- Detail (tell me more about that, that's very interesting')
- Clarification (I don't quite understand, but you said earlier)
- Explanation (Why? How come?') (Schatzman & Strauss, 1973)

For both groups, these questions were predominantly asked at the end of the interview. I made a note of the buzzwords or statements made by the respondents during the interview and then addressed them at the end of the interview. I did not want to ask them for immediate clarification or details as the statement was made because I did not want to disturb, on one hand, the flow of thoughts or impromptu conversation and on the other hand, I felt that my asking could distract the respondents from the topic and result in digression.

Attentive listening can be influenced by several factors, namely:

- Paper-focused on schedule-watching and note-taking, where the interviewer is busy making notes and looking at the question schedule;
- comparing, where the interviewer compares what the interviewee says with his/her own experience or history;
- mind-reading, where the interviewer tries to figure out what the respondent is thinking;
- rehearsing, where the interviewer is busy rehearsing the follow-up question;
- filtering, where the interviewer listens to hear the things s/he is looking for and filters out information that may be considered irrelevant;
- judging, where rapid evaluative judgments are made about the respondent and this hasty premature labelling are not re-evaluated;

- dreaming, where the interviewer is half-listening as something said by the interviewee triggers off other associations that make the interviewer inattentive to what is being said;
- identifying, where the interviewer associates every experience expressed by the interviewee to his/her own;
- advising, where the interviewer gives advice to fix things;
- sparring, where the interviewer is occupied with arguing and debating with the interviewee,
- being right, where the interviewer has the desire to disagree and correct;
- derailing, where the interviewer suddenly changes the topic;
- placating, where the interviewer gives the impression of partially agreeing rather than giving the interviewee full attention. (McKay, Davis & Fanning, 1983).

Referring to the summarised factors listed above, I can assert that although I was more focused on active listening, I experienced paper-focused on schedule-watching and note-taking, with both groups as I was busy making notes, this was more the case in the German interviews; rehearsing, where I rehearsed the follow-up questions in German; mind reading at times, this occurred in two interviews with a women immigrant, where I felt that the respondents were not fully involved in the conversation and gave me the impression of being preoccupied, which was true as she mentioned at the end of the interview that she was anxiously waiting for an important parcel; and in the case of a general practitioner, who was expected to go on a house call; and indeed filtering as through the process of filtering I extracted the buzzwords and later asked the respondents for further clarification or details.

When comparing the interview timing, it can be said that in general, the interview times range from around 13 to almost 80 minutes. The average time was between 25 and 30 minutes for the interviews, which indicates a consistent pattern as regards time and speed of interview. However, it can be assumed that a faster pace encourages answering less carefully (Loosveldt & Beullens, 2013).

I did experience this with two participants – one in each group, as mentioned above, that I had the feeling that the respondents were being polite and answering the questions but seemed either preoccupied or distracted. The women immigrant Irene, in particular gave very brief, short responses as she was anxiously waiting for an important packet. This can also be recognised in the duration of her interview (13:33 minutes). It was the shortest interview among the women immigrants. See Table 9. The general practitioner Hermann, had to go on a house call and so understandably wanted to be *"to-the-point"* in his replies. The duration of his interview was the shortest among the male doctors (21:28 minutes), see Table 10, however, although I could not ask him too many questions for further clarifications, I must say he did elaborate on a few questions I had asked.

All in all, none of the participants from either group appeared reluctant to answer any questions. This may be due to several factors, namely:

- The rapport established before and during the interview with the participants.
- My origin as an immigrant was known to the participants, so the group of women immigrants could identify themselves well with the research project, although I did not position myself till after the interview, and I only responded on my experiences with doctors when specifically asked by my participants. The doctors, on the other hand, did not ask me about my origin but some wanted to know what motivated me to work on this research.
- The general practitioners found the research project very interesting and were willing to share their experiences despite time constraints.
- The time and venue selected was purely at the convenience and choice of the participants.
- My conscious effort to reassure the participants and make them feel at ease, by nodding my head, using paralanguage like "*Hmm"* or "*Mhm"*, smiling or saying words like" *right"*.

- The "*one-off*" relationship that is created during the interviews assures anonymity and the participants were perhaps more forthcoming in responding, as it is seldom that our paths will cross again.
- The symmetrical relationship that was shared with both groups, especially with the general practitioners, where no power inequalities were sensed nor experienced.

4.5 TRANSCRIPTIONS

These 18 interviews of the main phase, have also been audio-recorded and then turned into text by transcribing the discussion. They were transcribed in the language used in the conversation i.e. in German or English. In some cases, the women immigrants used German words in their sentences, which were translated immediately into English in the transcripts. The German words used have not been mentioned. Likewise, some general practitioners used Latin terminologies when explaining illnesses which again were explained in German immediately in the transcripts, the Latin word has not been mentioned.

Although transcription is a useful means for turning digitally recorded interview data into transcripts, methodologically speaking, transcription is the act of representing original spoken text (recorded talking data) in written discourse as well as analysing and interpreting instances of these data (Bird, 2005).

Transcription is, therefore, "*both interpretive and constructive*" (Lapadat & Lindsay, 1999, p.72). Field and Morse (1985) advocate "*word for word*" transcription and suggest the use of wide margins, and page numbering as useful ways to assist in the management of data. Wide margins provide the facility for making notes about the transcript at the relevant place in the document.

All transcripts have been transformed into two templates. One general template with wide margins where I have summed the most important initial ideas that emerged in the interviews. This is, in fact, the first step in thematic analysis, which states familiarising with the data, by reading through the transcripts and making annotations.

The second template was created for NVivo for the coding process and was imported from my database and stored in the software program, too. See section Appendices 10 and 11.

Due to time constraints, I decided to outsource the task of transcription. Like Poland (1995) recommends, the transcribers were informed of the nature and the purpose of the piece of research study undertaken as well as the importance of verbatim accounts. Written instructions on the transcription conventions had been developed as suggested by Kvale (1996), which were forwarded to the transcribers to ensure consistency in transcription (Seideman, 1998). Pauses, intonations, emotional expressions such as laughter, etc. as well as sighing have been included in the transcripts. See section Appendices 9 and 12-13 for transcription conventions and excerpts of transcripts.

Each transcript after the initial transcription process has been reviewed to ensure that consistency is maintained. This also took away my fear, that I could distance myself from the interviews if I did not transcribe them myself. I must affirm that by re-listening to the recordings, I could not only check the accuracy and consistency of the transcripts but also relive the interview and add some comments in hindsight to the memos, which were drafted immediately after each interview. See excerpt from memos, in section Appendices 18.

As Matheson (2007) points out, transcribing one´s data "*provides a unique opportunity for [researchers] to critique their own work and potentially improve upon their interviewing technique*" (p.549). Although I did not transcribe the data, this statement holds for the pilot study where I learned what kind of questions should be avoided and changed my technique for all forthcoming interviews in the main phase. Furthermore, listening to the verbal data enabled me to see what themes were emerging and to reflect on what the participants had been asked.

Silences are important aspects of conversations and need to be considered within the transcription and analysis phases. According to Poland and Pederson (2016), silences can have many, and profound, meanings. These might include resisting a

response, waiting for further expansion on the question, waiting for something to occur, or "*self-censorship*". Thus, such silences may require interpretation, with the researcher spending time analysing the moment within the context of the whole interview. I have made a conscious effort in noting the pauses of my participants in my interview memos. For instance, Dana was slow in speaking and had long reflected pauses.

As maintaining authenticity of the lived experiences in the transcripts has been an important aspect, the participants' syntax, the use of dialect and slang has been retained in the transcripts so that they sound as natural as possible and the intended meaning is successfully communicated or understood. The only change that was made, as mentioned earlier in this section, is that the German words such as *Wahlarzt* or *Arbeitsamt, TGKK* or *BVA* and so on, which were used in the conversation by the women immigrants have not been mentioned in brackets, the English equivalents have been written in the transcripts. This also holds for the general practitioners, who employed Latin terminologies to define illnesses.

4.6 ETHICAL MINDFULNESS

Additionally, as it is the ethical responsibility of the researcher to keep the information provided by the respondents confidential and anonymous, the transcribers were not given any names but just the alphanumeric code that the respondents were assigned. The transcribers also had to sign a non-disclosure agreement for their transcription services. See section Appendices 15.

The allocated alphanumeric code enables the swift retrieval of the data, on one hand, and permits tidily organised data management, on the other hand. In addition, pseudonyms were given to each participant and used during the analysis of the findings. Moreover, a transcription protocol, which entails demographic details on the participant as well as the date and place of the recording, has been created.

4.7 EVALUATIVE RIGOUR

Qualitative and quantitative research have different purposes, goals and methodologies, therefore, the evaluative measures to assure scientific rigour should also be appropriate to the design of the research (Lincoln & Guba, 1985). In the case of qualitative research, Leininger (1985) suggested six criteria for evaluating qualitative studies, namely:

- Credibility
- Confirmability
- Meaning-in-context
- Recurrent patterning
- Saturation
- Transferability

Credibility refers to the truth and accuracy of the findings. In this research, the data gathering during the interviews was determined by me - the interviewer of the participants with the aim to be accurate. They have also been audio-recorded to obtain the accuracy. Moreover, the participants were asked for clarification during the interview, which, on one hand, elicited further information, on the other hand, also validated the content of their statements. Member checks for the accuracy of the transcripts were also offered to all participants. Only two women immigrants WI_BDL_06 (Dana) and WI_AI_08 (Maya) interviewed in the main phase made use of this provision.

Confirmability refers to reaffirming what the researcher has seen or heard in relation to the phenomena under study (Leininger, 1985). All the measures stated above also support the criterion of confirmability.

Meaning-in-context relates to the significance of taking into account the value of the situation, event or experiences of the participant (Leininger, 1985). In this research, the open-end questions and the good rapport with the participants primarily encouraged them to narrate their experiences in much detail as possible. In the verbatim transcription, it was

not only the content (What) but also the context (How) that was taken into account. For instance, pauses and emotional aspects such as laughter have also been included. Inclusion of non-verbal cues denote, on one hand, reliability of the work, on the other hand, give the reader a holistic picture of the context in which meaning was constructed.

Recurrent patterning according to Leininger (1985) are the repeated experiences, expressions and activities. Themes, for example, reflect the recurring patterns that emerged from the data. In each interview after the coding process, themes were identified, and common themes have been noticed across interviews of the respective groups.

Saturation refers to the exhaustive exploration of the subject and no further data or insights are forthcoming from the participants (Leininger, 1985). Saturation is said to have been reached, when the information becomes repetitive and redundant. In the case of the interviews, it can be said that saturation was reached on two levels. First, during the interviews I let my participants speak till they felt that they had nothing more to narrate. Second, with 21 interviews in total, I had the feeling that my learning curve had now peaked, and the point of saturation had been reached at this level. I was not getting any new insights into the phenomenon and duplication of content with similar views and expressions was being expressed.

Transferability suggests that findings from the study can be transferred to another similar context or situation without losing the meanings and interpretations (Leininger, 1985). The purpose of this study is to gain in-depth knowledge of the communication process in a medical setting and to understand whether and which cultural dimensions are involved. The themes emerged in this research could be researched further in detail in other similar contexts.

4.8 SUMMARY OF CHAPTER FOUR

To sum up, it can be said that all interviews including the pilot phase interviews have been carried out over a period of 10 months. A total of 25 interviews have been conducted, of which 21 interviews have been analysed. They have been held at a place and time convenient to all participants.

Four interviews from the pilot phase have been excluded. The mistakes made in the pilot study as regards some questions have been taken into account and consciously avoided in the main phase. All participants gave their interviews in the language of their choice either German or English. All interviews have been audio recorded, stored and transcribed in the respective language following the set transcription rules. Ethical mindfulness has been considered by securing the protection and anonymity of the participants.

Finally, reflection of personal experiences during this entire process has been documented as well as the measures such as transcription verbatim, member checks, saturation point, etc. taken to meet the standards of rigour in qualitative research have been described.

5 Chapter Five Data Analysis

5.1 INTRODUCTION

This chapter deals with Thematic Analysis (TA), the method used to analyse the data; explains the analyses process; it provides reasons for using the qualitative data analysis software program NVivo; the multi-setting interviews, as well as the use of the subject I and finally, justifies the rigour of the analysis process.

The objective of the analysis is exploratory in nature to obtain answers to the research questions from my sources - the women immigrants and the general practitioners. So, the focus here is on what emerges from the interaction between myself and my participants. It is from the content of these 21 interviews that the themes have been identified. Thus, it can be said that an inductive approach has been applied.

Furthermore, this analysis is not a linear process where the researcher moves from one phase to another, but more of a recursive process, where there is back and forth movement throughout the phases. The following Table 11 sums up the analysis approach taken:

Data Analysis Approach	
Exploratory in nature	Content - driven
Inductive approach	Data generated
Specific codes /analytic categories not predetermined	Codes derived from the data
Purposive sampling	Women immigrants and General Practitioners
Recursive process	Back and forth movement throughout the phases

Table 11: Summary of Data Analysis Approach

5.2 THEMATIC ANALYSIS (TA)

Thematic analysis (TA) is a method for identifying, analysing and interpreting patterns of meaning ("*themes*") within qualitative data (Clarke & Braun, 2017). Identifying and interpreting data is the key to this method, however, this does not mean that all data identified and interpreted, are guided by the research question because very often the research question can evolve in the coding and theme development process.

Thematic analysis is a data analysis technique used in phenomenological studies that involves data from interviews with study subjects to discover themes or categories of experiences as viewed from the subjects' perspective. It is a strategy in phenomenological research that involves recognising common themes in textual data (Dempsey & Dempsey, 1996, p.145).

Furthermore, flexibility is a trademark of TA. Flexibility in terms of sample size and constitution, the data collection method and the approaches to generate meaning in research questions. Thematic analysis can be used to identify patterns within and across data concerning participants' lived experiences, views, perspectives, as well as behaviour and practices. It can also be used to analyse small and large data sets from 1-2 participants to 60 and more participants, homogeneous and heterogeneous samples and almost any type of data collected through techniques such as interviews and focus groups as well as surveys and story completion can be analysed (Clarke & Braun, 2017).

Morse and Field (1995) state that thematic analysis involves the search for and identification of common threads that extend throughout an entire interview or set of interviews. Themes are usually quite abstract and therefore, difficult to identify. Often the theme does not immediately "*jump out*" of the interview but may be more apparent if the researcher steps back and considers. "*What are these folks trying to tell me?*" The theme may be beneath the surface of the interviews (latent) but, once identified, appears obvious. Frequently, these themes are concepts indicated by the data, which once

identified, appear to be significant concepts that link substantial portions of the interviews together (pp.139-140).

Since the aim of this research is to understand the communication process between the women immigrants and the general practitioners and to explore the communication dimensions and if or to what extent culture plays a role in this communication process, the thematic analysis method has been employed to identify the experiences or recurrence of experiences of the two groups of participants that are manifested in patterns such as ways of thinking, feeling or acting.

I have striven to extract themes from the interview data that I acquired from both groups and subsequently, to highlight and analyse these representations of important aspects and issues in the medical setting encounters of women immigrants and general practitioners.

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5.2.1 Thematic Analysis Process

Braun and Clarke (2006) have conceptualised six phases of the process which I have closely followed and conducted. The six phases, which serve as a step-by-step guide have been summed up in Table 12 below and explained in detail in the subsequent sections.

	Phase	Description of the Process
1.	**Familiarising oneself with the data**	Transcribing data, reading, re-reading data, noting initial ideas.
2.	**Generating initial codes**	Coding features of the data in a systematic manner; collating data relevant to each code.
3.	**Searching for themes**	Collating codes into potential themes, gathering all data relevant to each potential theme.
4.	**Reviewing themes**	Checking if themes work in relation to the coded extracts (level 1) and entire data set (level 2) , generating a thematic map of the analysis.
5.	**Defining and naming themes**	Ongoing analysis to refine the specific of each theme, the overall story the analysis tells; generating definitions and names for each theme.
6.	**Producing the report**	Selection of extracts, final analysis of those extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 12: Thematic Analysis Phases

5.2.2 Phase 1. Familiarising with the Data

If data have been collected by the researcher through interactive means, one tends to come to the analysis with some prior knowledge of the data and possibly some initial analytic thought. It is vital that the researcher immerses him-/herself into data and be familiar with the depth and breadth of the content. Immersion denotes repeated reading of the data and involves active reading – searching for meanings and patterns. This phase is a fundamental step of the analysis. In this phase, it is advisable to take notes or mark ideas for coding that will be carried out in the subsequent phases (Clarke & Braun, 2017).

Moreover, data collected in my research verbal data like interviews has been transcribed. Researchers say that the transcription phase is also seen as a key phase of data analysis and is recognised as an interpretative act, where meanings are created, rather than simply a mechanical act of putting spoken sounds on paper (Lapadat & Lindsay, 1999).

There is no hard and fast rule nor a set of guidelines in producing transcripts. However, the transcripts must be thorough orthographic transcripts - a verbatim account of all verbal and sometimes nonverbal utterances. It is important that the transcript retains the information from the verbal account in a way, which is "*true*" to its original nature (Clarke & Braun, 2017

So, familiarising myself with my verbal data – the interviews was of paramount importance. I listened to the audio-recordings and reviewed each transcript to make corrections or additions in case my transcribers had omitted any information. Accuracy of the transcripts was the key to this process. During this process, I relived the interview and could also make additions to the memos written after each interview.

Next, I created two templates for each transcript. One was for NVivo and the other one was for my paraphrases and annotations. As you can see from the templates 10 and 11 in the section Appendices, both layouts have one and a half spaced format and in the second template, the wider margin on the right-hand side has been created for my summaries and notes. This column is single-spaced and the lines are numbered here. The data in both templates have been separated into paragraph-length units when topic or subtopic shifts occur. Each speaker starts on a new line. The transcripts without notes were formatted for the NVivo for the coding process.

Finally, I read all transcripts again. The second time I read through the interviews, I paraphrased the passages based on the keywords, themes and ideas that appeared in the texts. This method of paraphrasing is suggested by Mayring (2007) which I found very important as I got an idea of the codes and definitions that I would

assign. Moreover, this also helped me in cross-checking once I had assigned codes to all the extracts of data with NVivo.

5.2.3 Phase 2. Generating Initial Codes

Once the researcher has familiarised him-/herself with the data and generated an initial list of ideas about what is in the data, the phase of producing initial codes from the data commences. Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst and refer to "*the most basic segment or element of the raw data or information that can be assessed in a meaningful way regarding the phenomenon*" (Boyatzis, 1998, p.63).

Coding is described by Coffey and Atkinson (1996) as a conceptual device for questioning one's data and for opening new meanings. It is a way of relating one's data to concepts. In essence, it helps in enabling the researcher to think about how a concept/category identified may relate to other categories and whether evidence of these is found in the data. It is the creating of links between data and concepts and vice versa.

Coding can be data-driven, or theory-driven and that influences the coding approach. Data-driven themes will depend on the data. Moreover, it also depends if the researcher is aiming to code the content of the entire data set or whether the researcher is coding to identify particular and possibly limited features of the data set. Finally, coding is done manually or through a software programme (Seale, 2004).

Furthermore, it is inductive and iterative as derived from the material and to arrive at a final set of codes one goes through the material several times. The codes are revised as new ways of looking at the data emerge. It is important to work systematically through the entire data set and thus, in this phase following aspects are important:

- Coding as many as potential patterns as possible – may be interesting later
- Code extracts of data inclusively – keep a little of surrounding data so that context is not lost

- Coding of individual extracts of data in many different themes is possible (Schreier, 2014)

5.2.3.1 Codes

Codes are researcher-generated constructs that symbolise or "*translate*" data (Vogt, Vogt, Gardner & Häffele, 2014, p.13). They are a word or short phrase that symbolically assign a summative, salient, essence-capturing and/or evocative attribute for a portion of language-based or visual data (Miles, Huberman & Saldana, 2014). Charmaz (2001) describes coding as the "*critical link*" between data collection and their explanation of meaning. This is because they lead us from the data to the idea and then from the idea to all the data of that idea (Morse & Richards, 2002).

The question often raised as to what is coded or can be coded? "*Human actions based upon, or infused by, social or cultural meanings: that is, by intentions, motives, beliefs, rules, discourses and values*" are coded (Hammersley & Atkinson, 2007, p.7). Researchers (Lewins, Taylor & Gibbs, 2005) provide a detailed list of types of things that can be coded as summarised below in Table 13.

	What can be coded	Examples
1	**Behaviours**, specific acts	Seeking assurance, bragging
2	**Events** – one off events; things people have done and tell them as a story	Moving out of home; starting a new job
3	**Activities** – these are of longer duration, involve other people within a particular setting	Going clubbing, conservation work
4	**Strategies**, practice or tactics	Staying longer at work to get promotion
5	**States** – general conditions experienced by people or found in organisations	Hopelessness, dissatisfaction
6	**Meanings** – meanings and interpretations are important pars of what directs participants' actions	
	a. What concepts do participants use to understand their world? What norms and values guide their actions?	The term "chilling out" is used by young people to relax
	b. What meaning or significance it has for participants, how do they construe events, what are the feelings?	Uneasiness, anxiety
	c. What symbols do people use to understand their situation? What names do they use for objects, events, persons, roles, setting and equipment?	A PhD is referred to as "a test of endurance"
7	**Participation** – adaptation to a new situation or involvement	About new neighbours " I have to keep my music down at night as the neighbours have young children"
8	**Relationships** or interaction	Seeing family "now my sister lives in the next road, she visits more and we've become closer"
9	**Conditions** or constraints	Loss of job, moving away
10	**Consequences**	Confidence gets dates, positive attitude attracts opportunities
11	**Settings** – the entire context of the events under study	University, workplace
12	**Reflexive** – researcher's role in the process, how intervention generated the data	Probing question "How did you feel when he said that?"

Table 13: Summary of possible Codes

For my coding or categorising process, I set down some rules such as, what will be coded; each code will be given a name and a broad definition as well as, if necessary, examples, the structure of the coding frame. I have mainly stuck to the term codes although they are defined as nodes in NVivo.

In general, the entire data set has been coded except the small talk that took place at the beginning and at the end of the interview. The explanation of the formalities such as the signing of the informed consent form, collecting of participants' demographic details have been excluded from the coding process. All interruptions such as telephone conversation with a patient or family members etc. have not been included.

Once this was decided upon, the process of segmentation was initiated where I divided the material into units of coding such that each unit of coding fits into one category of the coding frame. To avoid any confusion, unit of analysis are defined as the interviews and units of coding are those parts of the units of analysis which can be interpreted in a meaningful way concerning categories and that fit within one code or subcode of my coding frame.

The thematic criterion was used to divide the material into units of coding. Primarily, I considered each paragraph as a unit of coding which I looked into for concepts, subsequently, assessed according to the coding frame. This ensured that I did not overlook any paragraph. In this manner, I coded many patterns as they emerged. Topic changes also signaled the end of one unit of coding and the beginning of another unit.

The size of the units of coding varied. It was important for me to see that the concepts contained some background information or could be read as stand-alone. It is important for me that the surrounding data exist in the unit of coding when the unit of coding is examined in its comparative isolation. The context unit is that portion of the surrounding material that you need to understand the meaning of a given unit of coding (Krippendorff, 2004; Rustemeyer, 1992).

Next, the codes were defined in the following manner (Boyatzis, 1998; Rustemeyer, 1992):

- A name.
- A description of what I mean by that.
- Examples

- Decision rules if necessary, for subcategories

I call my main code **candidate code**. The first two requirements were fulfilled, i.e. each candidate code has been given a name. The description of the codes is intentionally broad. I did not feel the need of giving examples in all cases. The aim was to ultimately create two separate codebooks - one for each group which contained the name, definition, example if necessary, relationship i.e. if it is a candidate code or a subcode and the number of times it has been used as regards sources and references. See codebooks for both participants, in section Appendices 17 and 18.

After all initial codes had been defined the next step was subsumption. This is useful for the creation of subcodes. This is also a strategy proposed by Mayring (2007) which I followed to create my subcodes. Once the initial candidate codes had been determined, I had an idea of what I was looking for. Now that the perspective has been determined, I looked into the data again for concepts related to that perspective. When I came across such a concept, I created a provisional name or label and this marked the first subcode under the candidate code that I was focusing on.

I continued this procedure through all units of analysis and when I came across another relevant unit of coding, I checked whether this unit of coding fits into the subcode created. If the meaning or locus of that unit of coding is similar to the meaning of a unit of coding already looked at, then this unit of coding was subsumed to the already existing subcode. If the locus of that unit of coding was different and highlighted a new concept then a new subcode was created. These steps were repeated for all units of analysis. The *candidate codes* in my research have been indicated *in italics* and the *subcodes* have been indicated *in italics and underlined*, the *further subcodes* have been illustrated in *italics and double underlining* in all chapters.

Now that the candidate codes and subcodes have been created the coding frame was graphically conceptualised. Coding frame is a way of structuring material, with hierarchical levels where the main category constitutes the first higher level and the subcategories if necessary, form the second or lower level (Früh, 2009; Holsti, 1969). Furthermore, I tried to base my coding frame upon the following criteria:

unidimensionality, mutual exclusiveness, saturation and exhaustiveness. All these four criteria are important for the reliability and validity of the work (Schreier, 2014).

Unidimensional – each dimension in the coding frame captures only one aspect of the material. This is because unidimensional coding frames are parsimonious and provide a concise description of the material.

The subcodes in the coding frame mutually exclude each other i.e. each segment of the material is assigned to one subcode only (Krippendorff, 2004; Rustemeyer, 1992). A coding frame is said to be exhaustive if you can assign each unit of coding in your material to at least one code or subcode in the coding frame (Holsti, 1969; Rustemeyer, 1992). In my data there is also a code called *miscellaneous,* which contains certain themes, which are not directly relevant to the context but important.

Saturation – the criterion of saturation requires that each subcategory is used at least once during the analysis and no subcategory remains empty (Rustemeyer, 1992). In data-driven coding frames, this requirement is met by definition because if you have not come across something in your material that you would want to classify under a given category you would not create that category, to begin with.

The coding frame has been applied to material which is relevant. To decide what material is relevant and to differentiate between relevant and irrelevant material certain requirements were set. As mentioned earlier that rules have been set for coding the units of analysis. Apart from those units that were fully excluded, unanticipated information, which has emerged, has been collected and assigned the candidate code *miscellaneous.*

Relevant material is all extracts of data that primarily answer the research questions in the broad sense. Extracts of data that are related to the literature review also in the broad sense are considered as relevant. Information on the current political situation and other issues related to women in Austria or views of women immigrants on specialists have been categorised in the coding frame under candidate codes *specialists* and *miscellaneous* respectively. They will not be used in the analysis as

specialists' communication is a research topic in itself and the code *miscellaneous* cannot be considered exhaustive as it entails several themes like the Austrian political setting, the issues of women wearing headscarves, gender equality and the role of women in the society. It certainly cannot be discounted that these themes may have to some or to a great extent influence on the participants' worldviews, as also explained in Figure 3. Moreover, these themes were less in number and constitute insufficient units of coding to be even considered as further subcodes. Thus, they have not been taken into consideration in my research. Nevertheless, these themes would be important for further research.

The following hierarchical chart depicts the coding frame developed for one of the candidate codes *communication dimensions* for women immigrants, where the differences in consultation perceived by women immigrants are illustrated. As you can see this candidate code has two levels. The first level consists of three subcodes personal *connection*, *interaction* and *communication strategies*. The first two subcodes *personal connection*, *interaction* contain further subcodes *trust and comfort*, *role* and *rapport*, *listening* and *language barriers* respectively.

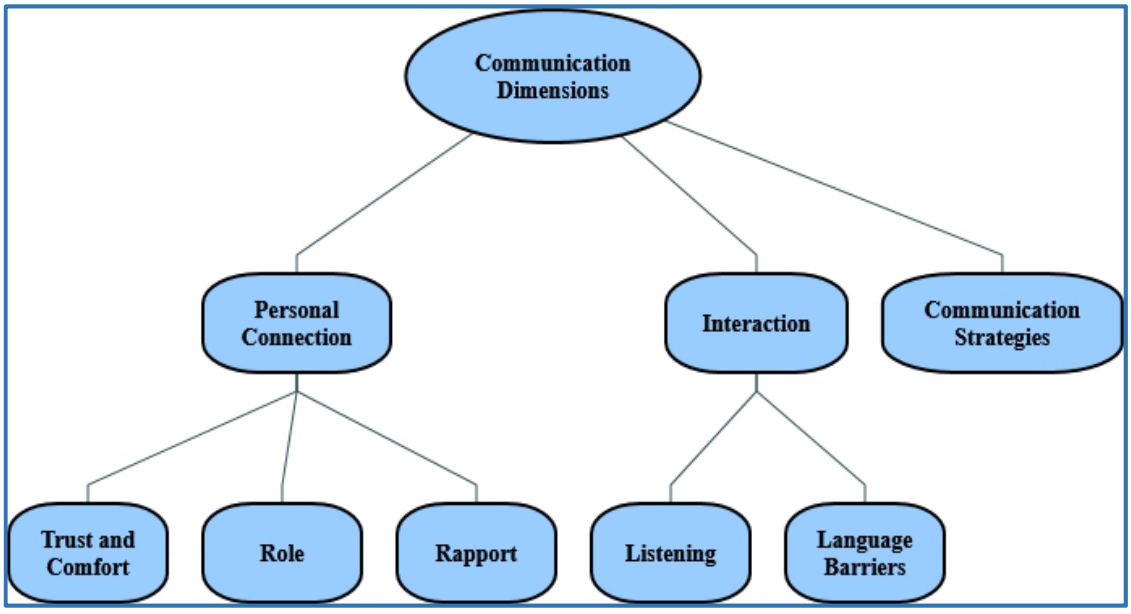

Figure 8: Hierarchical Chart of Code - Consultation Differences

The next hierarchical chart illustrates the coding frame conceptualised for the candidate code *consultation context* for general practitioners. Here, this candidate code also constitutes of two levels, the subcode *GP constraints* which, in turn, entails six further subcodes like *consultation procedure*, *time*, *treatment regimen*, *role*, *fear and anxiety* and *patients' education*.

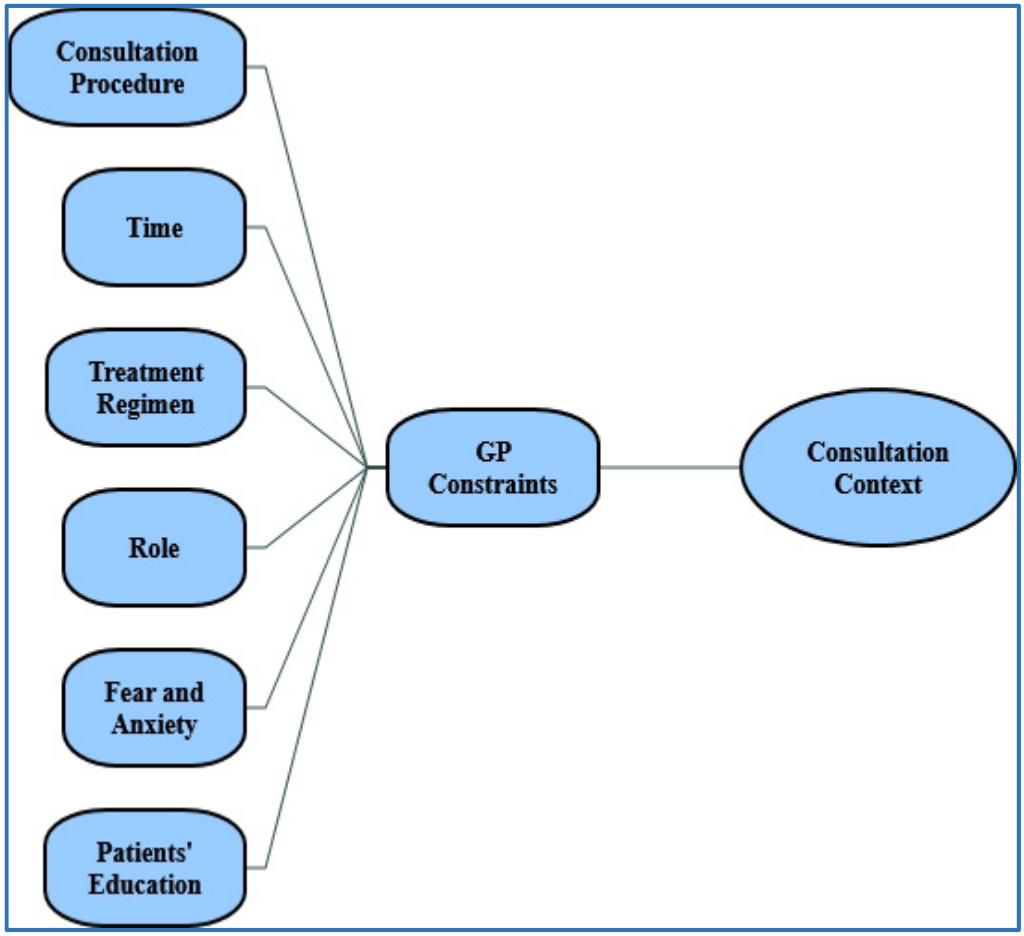

Figure 9: Hierarchical Chart of Code - Consultation Context

Next, the coding process entails first text segmentation – a technique for bounding text to assess and document the overall quality of the data and to facilitate the exploration of thematic elements and their similarity, dissimilarity and relationships (Guest, MacQueen & Namey, 2012).

In the process of segmentation, texts are abstracted from a larger context and perhaps stripped of important cues and layers of meaning. It is often difficult to define

where meaning begins and ends and how they interact or intersect. The larger context of dialogue is important as argued by Gibson and Brown (2009),

> *The contexts in which people speak are fundamental to the meaning which they are creating. By removing that context from the analysis, researchers remove the resources that would enable them to understand why the speakers said what they did or perhaps more accurately, 'why they said it how they did*' (p.189).

Moreover, coding takes place at two levels: semantic or manifest meaning and latent or implicit meaning. In the semantic approach, the themes are identified at face value so to say – the surface meaning of the data is taken into consideration and the researcher does not look beyond what the participant has said. The patterns in the semantic context are summarised and interpreted and it is attempted to theorise the significance of the pattern and their broader meanings and implications to previous literature (Frith & Gleeson, 2011; Patton, 2002).

At the latent level coding goes a step further beyond the semantic content of the data. Here the underlying ideas, assumptions that are theorised as shaping the semantic content of the data are examined. The development of the themes themselves involves interpretive work and the analysis produced is not descriptive but theorised.

In the case of my research, following all the rules drawn up, the coding process started in general from the point when the first question was posed to the respondent and ended when the last question was answered, and the respondent had nothing more to add to the related question or topic in general.

While reading through the data during the coding process, I identified a beginning and an ending point for each paragraph. After the data had been segmented, I identified an instance of meaning in the unit of coding, noted its locus and described it by assigning a code to it. The key-word-in-context or KWIC approach has been to identify a word or words as the locus for a theme or concept in units of coding without predefining the textual boundaries of that locus.

To cite an example of the KWIC approach: The "*straight forward procedure*" here, in the unit of coding, refers to the general practitioner's procedure. This unit of coding has been coded under the code *GP Procedures*.

WI - Maya, says, "I think about two weeks ago, ahm, I was at his place because I had a bad throat infection. And it was quite a straight forward procedure. I went in, dropped my e-card, they had the number, he saw me, he made some examinations and recommended that I stay at home, take a leave from work. He gave me my work ah thingy that I need to show at work."

The semantic and the latent level of coding were also applied in the coding process.

GP - Susanne says, "To compliance, good compliance is achieved by investing time, through conversation as the patient senses that I am taking care of him."

In the above unit of coding, we can see at the semantic level, the locus of the extract here is compliance, whereas the following unit of coding denotes the latent level of meaning.

GP - Jacqueline says, "Well, it happens every now and then. We are not open too long. One has to have locum doctors and one can see that the patients come again to their GP. This reinstates that the bottom line is it suits them fine."

This process of open coding was conducted throughout all units of analysis using the three approaches of identifying meaning. Moreover, as in the coding process, de-contextualisation takes place, where the unit of coding is removed from its surrounding context and examined in its comparative isolation as mentioned earlier in this section, I have tried when required to give background i.e. a context unit to each unit of coding.

5.2.3.2 NVivo

In this research, I used the NVivo programme purely for coding purpose. For that, I had to store the recordings and the transcripts into the database, I also wrote my memos as mentioned earlier on the interviews as well as on the entire coding process. This software also supported me in identifying patterns and relationships comparing the

different data sets, in creating professional data display as well as in reconceptualising the data.

The database is flexible so changes and adaptations could be made easily and are also transparent. I feel that there is a certain amount of thoroughness in data analysis. Once I finished my initial coding, I went through each code and read through the units of coding to see if they made sense on their own or if additional information or context unit was required. The possibility of "*jumping to source*" (Gilbert, 2002), where I could view the coded excerpt within its original context, increased the level of closeness to the data.

Admittedly I also felt that I was over coding or tending towards coding fetishism as referred to in the field, this could also indicate too much closeness to the data. For me, it was a balancing act of concern - not to be over coding and at the same time worry about missing out on relevant information. The chance to retrieve data anytime and the context is highly invaluable as it has made me intensively familiar with my data. Nonetheless, I have tried to strike a balance between closeness and distance from the data.

Various phenomenologists object to the use of QDAS as they feel that as the data is organised, labelled in zeros and ones which numbs them (the researchers) (Adams, 2006) and prevents them from being or dwelling with the interview texts in the way required to discover their essence. Furthermore, two researchers and a institution (Goble, Knight & East Carolina University, 2012), state that coding software noticeably distance researchers from their research as typical immersion is eluded and they spent their time fretting over questions such as "*Can this be coded?*" or "*Can we enter that into NVivo?*"

I found that despite my tendency to over code, NVivo gave my data a structure as I could organise my documents, identify, label and index the interviews. I could also review the development of a conceptual understanding of my data. As this is a big

project for me, the biggest so far which I am pursuing all alone, this tool helped me structure my data well.

In the 21 documents that I have coded, I have to admit that I fell into part of the coding trap, I have 899 coding references in the group of women immigrants and 560 coding references in the group of general practitioners. There were groups of codes that I deleted or merged; one set of codes *specialists* did not directly relate to the research question; however, it was a great experience learning how to code, decode and recode if I may say so. I cannot agree with the above researchers who claim that QDAS excludes one from immersion. I had all the data i.e. recordings, transcripts, codes and my memos stored in one place and speaking for myself, I can assert that the coding and writing memos as well as listening to the recordings, revived memories, which I have added to the memos. This did not make me feel that I was dealing with anything other than words of human beings unlike Heidegger (2008) who views technology as "*dehumanising*".

Additionally, "*Closeness to data*" is often referred to as living knowledge of the content: "*being able to recover the sights, sounds and experiences of being in the field*" (Fielding & Lee, 1998). "*Closeness*" has been equated with positive sensations associated with handling field notes and "*distance to data with the discomfort associated with the limitations of early software screens*" (p.75). Thus, the term "*closeness to data*" conflates two constructs: knowledge of content and pleasure in handling data (Gilbert, Rose & Shelton, 2002).

Although closeness to data is highly valued in qualitative research, distance from the data is equally important. Richards (2016) observes, "*Qualitative research requires an in-out process: researchers have to achieve and manage both ways of zooming in and ways of achieving a wide-angle view*" (p.324).

I did take breaks, such as a day or two when I thought that I was being bogged down with the reading and re-reading of the transcripts or reviewing the coding. These breaks created distance and this process of closeness and distance from my work was a definite help in my analysis, as this "*zooming in and zooming out*" as I would call it, in

other words immersing into the particular extract of data by zooming in and then getting the "*wholistic*" view (Van Manen, 2014, p.320) by "*zooming out,*" helped me in the process of maintaining a wider perspective for a more balanced interpretation.

I can say that through closeness to my data, I became familiar with the content and could see the subtle differences and the distance allowed me to follow the process of abstraction and synthesis. Furthermore, it suited my goal for using this tool, which was to create a structured and transparent coding process that shows the hierarchical maps as well as create cross-case comparisons between the two groups.

5.2.3.3 Multisetting

This piece of research has a multilingual character as two languages were used during the research phase, namely German and English, as the study has been undertaken in the German-speaking belt. With the exception on one, all the women immigrants were interviewed in English as they are either English native speakers or very conversant in English.

The second group of participants, the general practitioners responded solely in German. Since I have been living in the German-speaking belt and have also studied German, I speak the language fluently and decided not to persuade these participants to speak in English. I think that a high-quality interview results in rich data and this is obtained when respondents speak in the language of their choice. Hence, verbatim transcription of that data was done in German, subsequently, translated into English.

Some women immigrants used German words such as Facharzt (specialist)/Frauenarzt (gynecologist)/Gebietskrankenkasse (healthcare system)/Gesundenuntersuchung (physical examination) in their interviews. These words were spontaneously used as they were convenient and since the topic revolves around doctors and health, it was easier and quicker to convey meaning using them.

This type of borrowing words between languages is known as code-switching and in sociolinguistics is considered as a local communicative, pragmatic switch to the language in which bilinguals or multilingual know a relevant vocabulary to be more

precise or more able to discuss a particular topic (Bradby, 2002; Haugen, 1987; Miller, 1983). The German words and likewise, the Latin words used by general practitioners to name some illnesses as mentioned earlier in chapter 4, section 4.5, are not mentioned in the transcripts.

The German set of data has been translated from this source language into English the target language. Translation defined as transcribing the text of a source language into the target language (Gau, Schlieben & Ströbel, 2008), is more than just "*changing the words*" or as Temple and Edwards (2002) point out: "*communication across languages involves more than just a literal transfer of information*" (pp.4-5).

Having studied translation, I took upon the task of translating all the transcripts. I also sought help from a colleague who, at times, reviewed the work with me and discussed with me some extracts when I was not sure if I had managed to transmit the right message. She is Austrian native and is well conversant in English; she also works in the healthcare sector. Since she originates from this region and speaks the Tyrolean dialect as well, she was the ideal person to seek advice from when I was uncertain of specific dialect terms or meanings. Intra-reliability with an expert is worth the effort as I needed to understand and convey the "*actual*" meaning (Temple & Edwards, 2002).

As the paraphrases and annotations in the first phase were written in English. In this manner, a specific process of translation had already occurred. According to Baumgartner (2012), translated data may lack some of the language-inherent and language-specific nuances and shades that may result in a limited understanding of the key experiences narrated in that specific interview, it would undermine the purpose of familiarisation step of the data analysis process.

Despite this claim, I thought it would be best to start in the target language, English, from the very beginning. I think I was able to understand the overall atmosphere of the interviews and could build a coherent high-level understanding of the scope and context of the key experiences. Secondly, the code list and the codebook here were also created in the target language from the very beginning.

This was mainly because the entire research has been written in English and as the aim of the coding system is to document linkages and comparison between the two groups of respondents and to highlight the phenomena in the entire data material, it would be appropriate to use English the target language from the very beginning for all material rather than using code lists in two different languages for isolated portions of data, in this manner the objective of the analytical step has been fulfilled.

Nevertheless, I must admit that most of the German spoken and transcribed is Tyrolean dialect which is, indeed, German language but has its very specific words and short forms that are representative of this region. The translations, however, are "*proper English*" where I have attempted to transpose the native's (here the respondents) point of view by trying to "*somehow get into the authors' head and behind the authors' eyes"* and to "*recreate in English the writers' linguistic perceptions of the world*" (Grossman, 2010, pp.82-83).

I have also intentionally left out the utterances and repetition of words. The main aim of translation has always been the transmission of the message i.e. not just translating simply words but the meaning and intention despite omitting the paralinguistic utterances. Although in this research, a unidirectional translation approach has been taken into account, I have tried my best to check for translation inconsistencies with the help of my colleague and to ensure that while translating the meaning of certain expressions and concepts do not get "*lost by translation*" (Filep, 2009).

Finally, the coding of the German set of data has been done in English. The English translation has been cited in the subsequent chapter 6, where I have reported the findings. See excerpt from German transcript and its translation in section Appendices 12 and 13.

The English data sets have been thoroughly examined by myself, whereas in the case of the German sets, I sought the help of another colleague, who is a researcher and an expert in the field of intercultural communication. She is also an Austrian native and it has been important for me to discuss, revise as well gain reassurance that I am on

the right track. Talking to her has been very helpful as it has prompted me to step beyond my data. At times, she questioned my interpretation and came up with suggestions, which also made me reassert my knowledge.

5.2.3.4 Multicoding

Several units of analysis have been coded into the many different themes they fit. Some units of coding have been coded once, some twice and some even three times. Others are coded under *miscellaneous* when no direct connection to the topic was observed. There has been no clear-cut assigning of codes to many units of coding as they are multifaceted in meaning.

Data, in this case, could not be distinctly bounded – as Tesch (1990) said data are within "*fuzzy*" boundaries at best (pp.135-138). I must say, I tried to retain all accounts that have appeared in the data sets. Thus, the process of simultaneous coding has been performed in the case of some units of coding.

Examples of multicoding:

WI - Dana says, *"At some points as I've complained about pain that I can't describe the pain so well in German ähm and my GP has, she will like immediately send me to an X-Ray. And then I've been to a specialist and he said you need to stop getting X-Rays, he says you've had too many. This is very dangerous. And so, I was like okay, well I don't know my GP always sends me for an X-Ray. (laugh) So, ähm, you wonder if they're just a little bit dismissive or if they're overcompensating*."

The above example is nested in the candidate code *consultation context* under the subcode *GP constraints in the further subcode gp procedures* as well as collated in the candidate code *emotions* under the subcode – *feeling uncertain*.

5.2.4 Phase 3. Searching for Themes

This phase kicks in when all the data have been initially coded and collated. The different codes are now sorted into potential themes and all the relevant coded units of coding are collated accordingly within the identified themes. In this phase, the codes

are analysed and considered how different codes may combine to form an overarching theme.

Researchers (Miles et al., 2014) define a theme as "*a phrase or sentence that identifies what a unit of data is about and/or what it means*" (p.139). Ryan and Bernard (2016) define themes as

> *abstract (and often fuzzy) constructs that link not only expressions found in texts but also expressions found in images, sounds, and objects. You know you have found a theme when you can answer the question, 'What is this expression an example of?* (p.87)

The term "*theme*" is used to denote the fact that the data are grouped around a central theme or issue. (Brink & Wood, 1994, p.215). A theme is used to describe a structural meaning unit of data that is essential to presenting qualitative findings. (Streubert & Carpenter, 1995, p.317). It is a recurring regularity emerging from the analysis of qualitative data. (Polit & Hungler, 1997, p.470). A theme captures something important about the data concerning the research question and represents some level of patterned response or meaning within the data set (Braun & Clarke, 2014)

Themes are not the exact words. Themes are the exact meanings implied and inferred from words, behaviours, and events (Germain, 1993; Opler, 1945; Spradley, 1979). Most themes are said to be implicit, implied, and tacit rather than explicit, declared, and easily expressed (Aamodt, 1991; Bernard & Ryan, 1998; Boyle, 1994; Emerson, Fretz & Shaw, 1995; Germain, 1993; Morse & Field, 1996; Opler, 1945; Patton, 1990; Spradley, 1979).

There is uniform agreement in the literature that themes emerge from the data that is, from analysis of interviews and/or recurrent behaviour or events in observational and experiential activities (Agar, 2009; Bernard & Ryan, 1998; Emerson, Fretz & Shaw, 1995; Germain, 1993; Leininger, 1985; Morse & Field, 1996).

Whereas the majority of the literature states that themes emerge from the data, the term emerge does not mean they spontaneously fall out or suddenly appear. There is

agreement that themes are "*extracted by a careful mental process of logical analysis of content from all data sources*" (Germain, 1986, p.158). There is also agreement that themes (a) unite a large body of data that may otherwise appear disparate and unrelated, (b) capture the essence of the meaning or experience, and (c) direct behaviour across multiple situations (Aamodt, 1986, 1991; Bernard & Ryan, 1998; Boyatzis, 1998; Boyle, 1994; Emerson, Fretz & Shaw, 1995).

Ryan and Bernard (2016) describe several tips to identify themes:

- Repetition: This is by far the most common theme-recognition technique and is based on the premise that if a concept reoccurs throughout and/or across transcripts, it is likely a theme. The number of repetitions needed to constitute a theme, however, is not set in stone and is a function of the theme's relevance to the research objectives and the analyst's judgment.
- Indigenous categories/typologies: This technique looks for local terms that may sound unfamiliar to the analyst or are used in distinctly different ways than in the researcher's conceptual framework. An example of this would be a participant talking about diseases in terms of "*hot*" or "*cold*."
- Metaphors and analogies: Metaphors and analogies can reveal interesting themes and insights within a data set.
- Transitions: Naturally occurring shifts in topical content by the participant may be markers for themes. It is essential to look for the transitions and note what is on either end of the change.
- Constant comparison/similarities and differences: This method is typically used in grounded theory. As the name implies, it involves systematically comparing sections of text and noting similarities and differences between sections.
- Linguistic connectors: In this approach, the analyst looks for words and phrases such as "*because*," "*if*," "*since*," "*as a result*," or any other terms connoting a causal relation. These connectors can indicate places in the text where a participant's system of logic is revealed.

- Silence/missing data: The absence of a theme can be quite telling. It could be telling if there is a good reason to expect participants will talk about something and they do not. This silence can be taken as an important indicator, therefore, documented. It may not be necessary to develop an explicit code for such a case, but at the very least, the observation of absence should be included in any report.

Visual representations such as tables or mind maps help organise the codes into theme-piles. Here the researcher starts to think of the relationship between codes, between themes and between different levels of themes i.e. main overarching themes and the sub-themes. It is quite likely that some initial codes may form main themes, whereas others may form sub-themes. There may also be a set of codes that do not seem to belong anywhere and so it is perfect to create a theme where these codes are housed as they do not at the moment fit into the main themes (Clarke & Braun, 2017)

Thus, in this phase candidate themes and sub-themes and all the extracts of data that have been coded to themes are collected, during which process one gets an idea of the significance of the individual themes. No codes are abandoned at this stage as there is no warrant that these themes hold as they are, or whether they will be further combined, refined, separated or discarded (Clarke & Braun, 2017).

In the case of my research, themes were initially captured in each group. In the following figure, the main themes that appeared in the units of analysis of general practitioners are depicted.

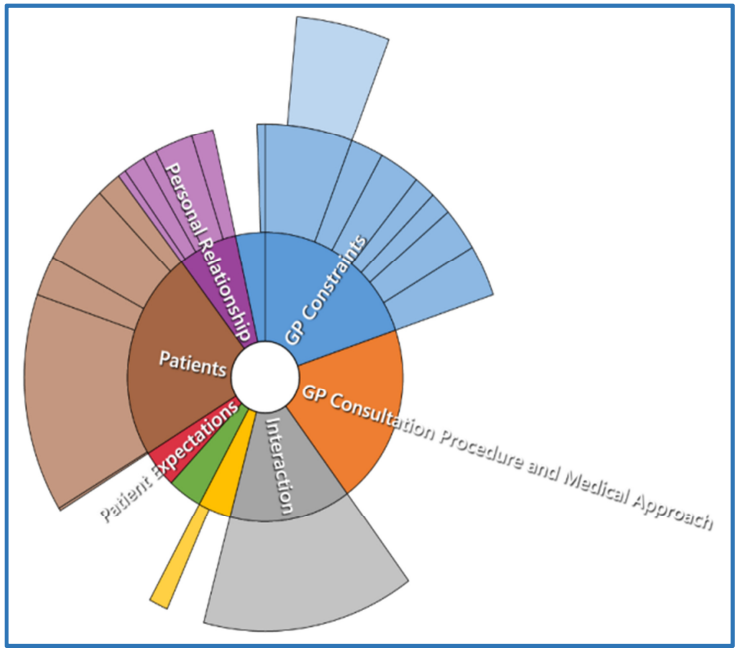

Figure 10: Initial Main Themes – GP

As we can see in Figure 10, a total of 9 themes emerged in the unit of analysis of the general practitioners. They are enumerated as follows:

1) GP Constraints
2) GP Consultation Procedure
3) Interaction
4) Patient Compliance
5) Patient Expectations
6) Patients
7) Personal Relationship
8) Social Security System
9) Miscellaneous

Out of nine themes that appeared, four salient themes came to the fore, namely: The *constraints* faced by the doctors during a consultation, the *interaction* with the patient, their *consultation procedure* and the *patient*. When talking about *constraints* the issues that came into light were *treatment regimen, patients 'education, fear and anxiety faced by patients, communication (verbal and nonverbal), the roles of doctor and patient, time.*

In the case of the second unit of analysis - the women immigrant 13 themes in total appeared and are presented in the following Figure 11.

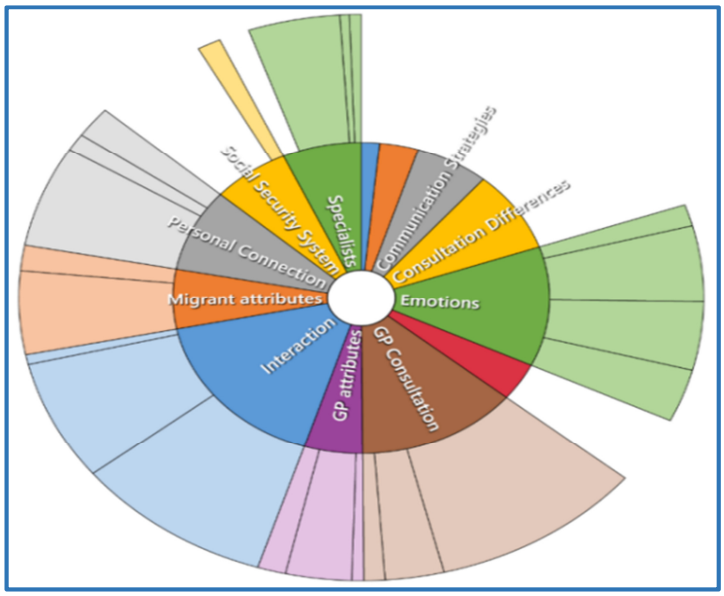

Figure 11: Initial Main Themes - WI

These main themes involve, mainly:

1) Acculturation
2) Austrian context
3) Communication Strategies
4) Consultation Differences
5) Emotions
6) Expectations
7) GP Attributes
8) GP Consultation
9) Interaction
10) Migrant Attributes
11) Personal Connection
12) Social Security System
13) Specialists

Five predominant themes stem from these 13 listed themes: *interaction* with the general practitioner, which refers to the communication aspect only; *GP consultation*, which involves the entire procedure; *emotions* that are evoked from the communication and consultation; *consultation differences* that are perceived by the women immigrants and *personal connection* such as rapport etc. with the general practitioner.

When I refer to the candidate code *interaction* the themes on *communication, language aspects and listening* are highlighted; the *GP consultation* deals with themes on the *general procedure, the time taken by the GP and the treatment regimen*; the *emotional aspect* spans across a spectrum of emotions from *positive to negative, uncertain to neutral*; in the code *consultation differences* the consultations experienced by the women immigrants in their home country and in Austria are compared and distinguished and finally in the *personal connection* the respondents talk on the *personal rapport, trust and comfort* as well as the different roles shared.

All the units of coding in this group have been assigned to a candidate code or a subcode. There was not a single unit of coding that was left out nor uncategorised thematically.

5.2.5 Phase 4. Reviewing Themes

After the data had been segmented and I had identified an instance of meaning in the unit of analysis, I noted its locus and described it by assigning a code to it. I read through each unit of coding assigned to a specific code to see if it made sense. In some cases when they did not, I had to go back to the data and retrieve the passage and recode it.

This phase commences when candidate themes have been identified and now may need to be refined. Sometimes some candidate themes, are not really themes, although they initially appeared to be so due to insufficient data to support them or data that is too diverse in nature; while other themes may collapse into each other (two separate themes may fall into one). Some themes may be broken into two or more themes (Clarke & Braun, 2017).

Patton's (1990) dual criteria for judging categories have been applied – internal homogeneity and external heterogeneity. Internal homogeneity refers to the meaningful coherence of themes and at the same time clear identifiable distinctions between themes. Here two levels of refining and reviewing is involved. At the coded level and the data set level.

At the coded level all the collated extracts for each theme are read through and checked if they are coherent in pattern. If the candidate theme does not fit, then it is checked to see if it could be assigned to another code or if a new code needs to be created. Sometimes a code needs to be created or discarded from the analysis. When assured that the candidate thematic map captures the contours of the coded data, the researcher can move to the next level.

The data set level – this is a similar process as at the coded level, however, in this case, it involves the entire data set. The validity of the individual themes in relation to the data set i.e. to ascertain if the themes work in relation to the data set, and to code any additional data within the themes that was left out in the initial stages, and rechecking to see if the candidate thematic map depicts an accurate representation of the data set as a whole. Next, it was important to recheck and revise the thematic map if necessary. Recoding is an ongoing process as TA is an organic process (Clarke & Braun, 2017).

This phase occurred twice. In the first round, I followed the above criteria at the coded and at the data set level, where I re-read all my codes and themes, and in several cases, the codes were relabelled like *personal relationship* was changed into *personal connection* or *GPs perception of patient fear* was converted into *fear and anxiety*. Codes were also collapsed into one and units of coding, which were named *GP personality* and GP attitude were merged into *GP attributes*; codes such as *communication strategies of GPs* and *patient familiarity* which were initially candidate codes were transformed into subcodes of *interaction* and *personal connection* respectively. Those units of coding that did not fully fit in any code were placed into candidate code *miscellaneous*. A subcode called *migration* that contains various themes expressing the current migration situation in Austria, was also created for this candidate code.

In the case of women immigrants, I converted the candidate code *communication* into a subcode of the candidate code *interaction*. Code *communication strategies* were converted into a candidate code because, in this code, there are themes which express the strategies applied by the women immigrants to strive for a successful interaction. Initial codes such as *challenges* and *general strategies* were deleted as they were either too diverse in definition or had insufficient units of coding assigned to them, thus, their units of coding were assigned to different relevant codes like *communication strategies*.

The subcode *legal implication* was also deleted as it contained just one unit of coding; the initial code *illness* was merged into *treatment regimen* and then deleted. Initial codes *GP rural and urban areas* were also deleted as their units of coding were assigned to subcodes *time* and *role;* likewise, initial codes *experiences with GP* and *attitude towards GP* were deleted after their units of coding were assigned to other codes; initial code *security* was deleted and was allocated to the subcode *trust and comfort.*

In both cases, it has been more of a refining process, as it involved making the coding frame more nuanced. I attempted to get rid of over coding and the messiness which partly comes with it. I revised all codes in this phase as I was solely concentrating on checking for inconsistencies. For example, when two categories conceptually overlapped, the two categories were collapsed into one when the distinction between the two did not seem worth preserving.

Although subcodes, in general, should be more than one in number to a candidate code this was not the case in my research. There are several categories with only one subcode such as candidate code *social security system* and the subcode *structural differences* in both groups as well as *miscellaneous* with the subcode *migrant.* I tried my best to make sure that there are not too many subcodes as it is difficult to keep track of them and to handle them. Streamlining the codes and subcodes during the entire process has been an important aspect here.

As mentioned earlier in section 5.2.3.2 where some researchers criticise the use of QDAS in the coding process as data organised in zeros and ones, this numbering also helped me in further refining the codes. The matrix coding query approach adopted and explained in section 5.4, was very helpful in reviewing the coding on one hand, and in ascertaining the confirmability of my study on the other.

In addition, I also adopted the process of intra-reliability where my research colleague supported me with German units of coding and code re-labelling. In order to see that my coding was not subjective and partial in nature, she coded some units of coding of the group general practitioners as well as checked and discussed the codes in that group with me.

In this manner, data was reduced and summarised but it also comes at the cost of losing the potential multiplicity of meaning of the material, for often I had to decide where a unit of coding could conceptually fit perfectly. Selecting, structuring, generating, defining and revising was done at least two times until all the data was coded. The size of the units of coding also varied in some cases as I collapsed smaller units into larger ones or I even divided larger units of coding into smaller ones, for instance, in the group women immigrants the initial candidate code *communication* was divided into two candidate codes *communication* and *communication strategies* and in the second round of refining the candidate code *communication* was turned into a subcode to *interaction*.

In the second round, I compared the code names given in both groups. This proved to be a good way to further refine the coding. I checked first to see if the names given were similar or identical in case similar themes had emerged, to further ensure consistency. For example, *GP or Migrant attributes*, *GP procedures*, *Social security system*, *acculturation*, *personal connection* and so on. This made me align the codes even further.

In the case of general practitioners, the candidate codes were reduced from nine to seven. The initial candidate themes like *interaction* and *personal connection* were moved as subcodes to candidate code *communication dimensions*. The initial candidate code *GP consultation procedure* was renamed *consultation context* with *gp constraints* as subcode and the initial candidate code *GP consultation procedure* now as a further subcode to this subcode *gp constraints*. The new and final candidate codes for general practitioners are as follows:

1) Communication Dimensions
2) Consultation Context
3) Patient Compliance
4) Patient Expectations
5) Patients
6) Social Security System
7) Miscellaneous

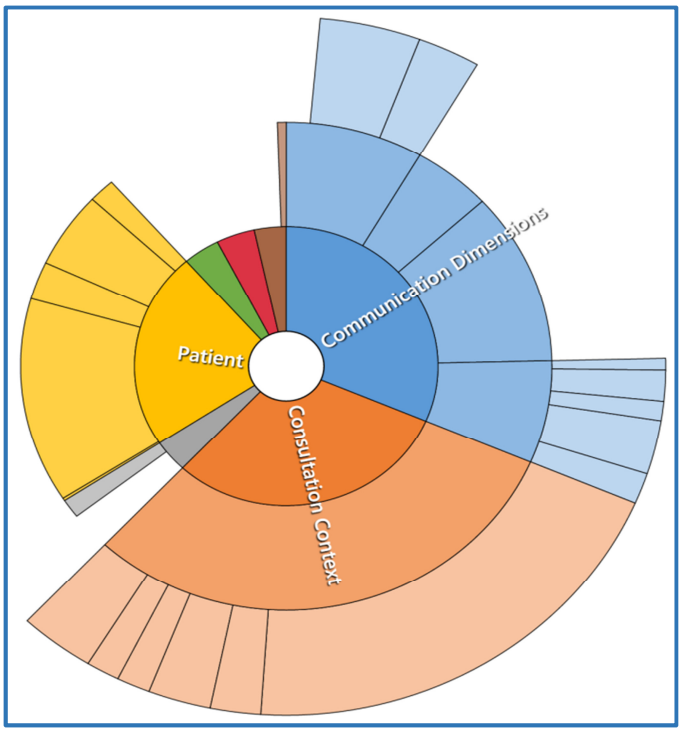

Figure 12: Final Candidate Codes – GP

In the following Table 14 the candidate codes and subcodes along with a summary of the themes as well as sub-themes that emerged in the group general practitioners, are described.

Codes	Sub Codes (if any)	Description of themes and sub themes
Social Security System	Structural Differences	Better organised translator system; less delegation appreciated.
Consultation Context	GP Constraints with further sub themes Consultation Procedure, Fear & Anxiety, Patients' Education, Role, Time, Treatment Regimen.	Language- extra effort, misunderstandings, hard to diagnose; translators – mainly family members; hierarchical role; less time, challenging; treatment – economical also win patients' trust. Difference between regular and new patients, western medicine has high standards, standard procedure, first vague idea then specific for diagnosis.
Communication Dimensions	Interaction; Communication Strategies; Communication Barriers with sub themes language barrier and translators; Personal Connection with sub themes Empathy, Familiarity, Listening, Trust, Understanding.	Language, pictures, drawings, leading questions for explanation, no telephone translators, straight to the point. Illness perception differs, more empathy required, must draw the line; same treatment for all; more familiarity better results, come again; attentive listening; building of trust, patient centered, how one deals with patients is important, friendly, be understood.
Patient	Acculturation, Ethnicity, Gender; Illness Perception, Patients' Personality.	Need to adjust to host country; national differences; fear and pain expressed strongly, different perception of health and body functions; shy and feel ashamed to talk.
Patients' Compliance		Mutual understanding, follow up mandatory consultations in some cases, 10% show non-compliant behaviour.
Patients' Expectations		Doctor possesses magic wand, increase in demands among patients, want expensive tests, behavioral differences national.
Miscellaneous	Migration.	Political setting, gender equality, role of a woman in society, women with headscarves.

Table 14: Candidate Codes, Subcodes and Description of Themes-GP

Likewise, in the case of the women immigrants the 13 initial candidate codes were revised to nine candidate codes. They are as follows:

1) Consultation Context
2) Communication Dimensions
3) Specialists
4) Social Security System
5) Patients' Expectations
6) Immigrants Attributes
7) GP Attributes
8) Emotions
9) Acculturation

The initial candidate codes *Austrian context* can now be found as a subcode in the candidate code *social security;* initial candidate codes *gp consultation* and *consultation differences* are now nested as subcodes in the candidate code *consultation context*; the same applies for the initial candidate codes *communication strategies, interaction, personal connection* that have now been placed as subcodes in the candidate code *communication dimensions*.

Two initial candidate codes have been kept at the same code level but their names have been changed from *migrant attributes* to *immigrant attributes* and from *expectations* to *patients' expectations* to maintain congruency and consistency in the naming of codes.

The final candidate codes for women immigrants are graphically illustrated in Figure 13.

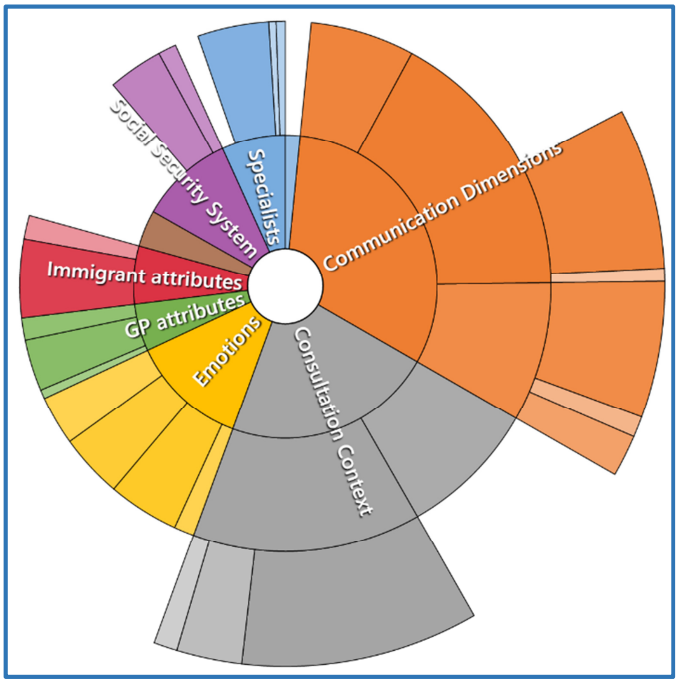

Figure 13: Final Candidate Codes - WI

Furthermore, I have summarised in the following Table 15 all the candidate codes and subcodes as well as a summary of the themes and sub-themes that emerged in the group women immigrants.

Codes	Sub Codes (if any)	Description of themes and sub themes
Social Security System	Structural Differences, Austrian context	Good hospital service, less opening hours, long waits for appointments, language issues, private and public insurance, with e-card easy, BVA more time. Good health system; scope of services is limited to time frame; traditional; conservative; not much international exposure; docs are strict, efficient and offer natural meds too (website).
Consultation Context	Consultation Differences; GP Consultation with further sub themes GP Procedures, Time, Treatment Regimen.	Straight forward, not many questions asked or could ask; challenging not very transparent; less time, rushedness, no follow-up questions, more assembly line; antibiotics, long treatments. Linguistic; behavioral; mannerism; tests not done; female assistant would be appreciated; time; casual relationship appreciated; no money making attitude; no pharma affiliation.
Communication Dimensions	Communication Strategies; Interaction with further sub themes Language Barriers, Listening; and Personal Connection with further sub themes Rapport, Role, Trust n Comfort.	Writing a script; learn to be straight to the point; translators; speak in simple German and slowly; combination of English and German; reach out with follow-up questions; non-verbal cues; clamp up; not ask for anything; rephrase when barrier. Straight forward, smooth, direct, less interest in the patient, medical jargon, no extra time to explain, dialect spoken; no patience to listen, not much attentive listening. Clinical like, more personal would be appreciated, little small talk, symmetrical role, tension in the communication; can put you to ease, non-verbal cues appreciated, more conversation appreciated.
Emotions	Positive, Negative, Uncertain, Neutral.	Polite, friendly, answer all questions, conversant; anxious, dismissive attitude, unprofessional remarks; friendly, satisfactory.
GP Attributes	Age, Personality, Selection of GP	Younger GPs are better in English; task oriented, professional, efficient, friendly; selection due to family and proximity.
Immigrant Attributes	Origin, Personality	Connections in home country, more CRM appreciated, more health conscious; more personal space; shy, open minded, flexible.
Patients' Expectations		Preventive actions, answers all questions; friendly; more interest in you as a person; stereotyping not nice; not to feel pushed, limited or threatened, puts you at ease, proper checks.
Acculturation		Adjustment to structural aspects; behavioural; adjustment strategies.
Specialists	Experience with specialists, Time, Trust	Procedural differences; Take their time; charges for tests.

Table 15: Candidate Codes, Subcodes and Description of Themes-WI

Thus, it can be said all units of coding have been assigned to a candidate code or a subcode or a further subcode. There has not been a single unit of coding that has been left out nor uncategorised thematically. With the help of all these visual representations, I have attempted to show the candidate codes created.

The last step in that second round has been to seek again intra-reliability from my colleague, who had worked with me in this phase in the first round, too. Her support has been invaluable as it has assured me that I am on the right track as well as has assured me that consistency prevails in my work, which is an important aspect given the credibility of my research. Memos were kept on the coding process which also incorporate my thoughts on planned and implemented actions. See excerpts of the reflective journal in section Appendices 20.

5.2.6 Phase 5. Defining and Naming Themes

Now once the thematic map of the data has been created and the essence of each theme has also been captured, I created a table for each group after the coding process with the codes and the respective extracts of data. Next, I went back to the extracts for each theme and organised them consistently and coherently.

In these extracts, the content of each code has not only been paraphrased but what is of interest about them and why has been identified and expressed in an accompanying narrative. A detailed analysis of each theme was then written. The story that each theme tells and the overall broader picture or story that the data narrates is told in the subsequent chapters in relation to the research questions.

Finally, I conceptualised the Table 14 and Table 15 as seen in section 5.2.5, which summarise the themes and sub-themes and show the candidate code and subcode these themes and sub-themes are assigned to.

According to scholars (Clarke & Braun, 2017), each theme itself should be considered and the relation of each theme to the others should be explained. By considering the relationships among and the content within each of these elements of a

research project, qualitative researchers can systematically organise their data to make analysis and the reporting of results more efficient and reliable (MacQueen & Milstein, 1999).

I worked on creating an overall picture – a thematic map of each group showing the relationships that appear through all the important themes. It is essential to determine how the various categories fit together and connect. The following graphical displays Figure 14 and Figure 15 shed light on the consultation cycles in the broader sense in each group.

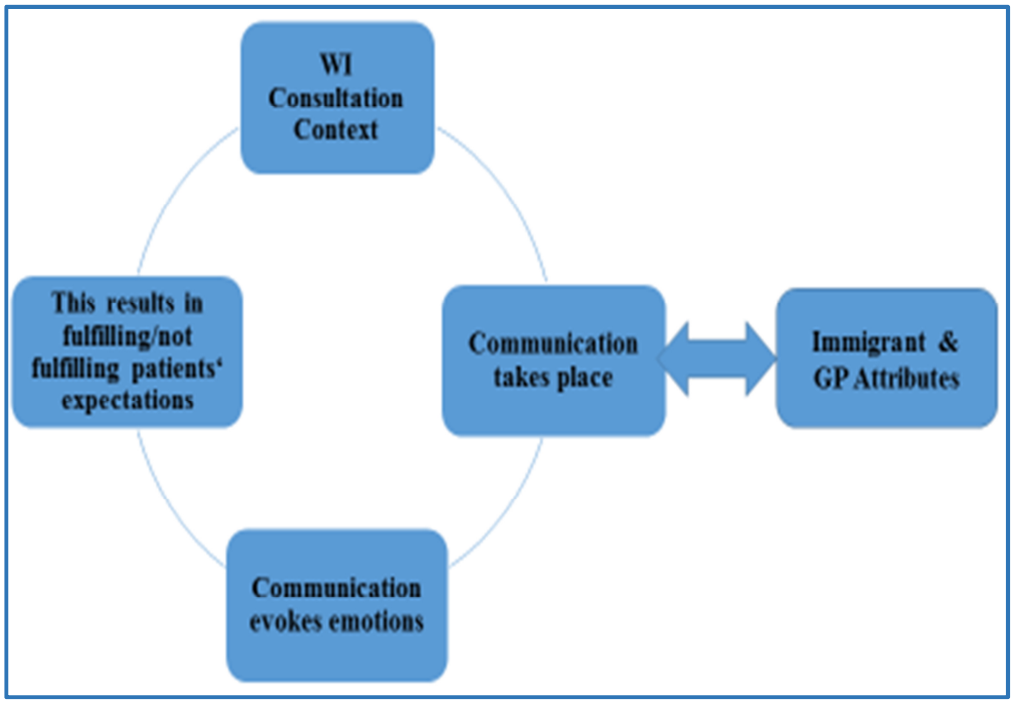

Figure 14: Consultation Cycle of Women Immigrants

In brief, it can be said that in the consultation context that takes place between the women immigrants and the general practitioners, the two participants communicate with each other. Depending on the kind of communication varied emotions are evoked. The emotions, in turn, influence the patients' expectations and this, indeed, has an impact too, on the ongoing or future consultations. I must add to it that the attributes of both participants also shape the communication process.

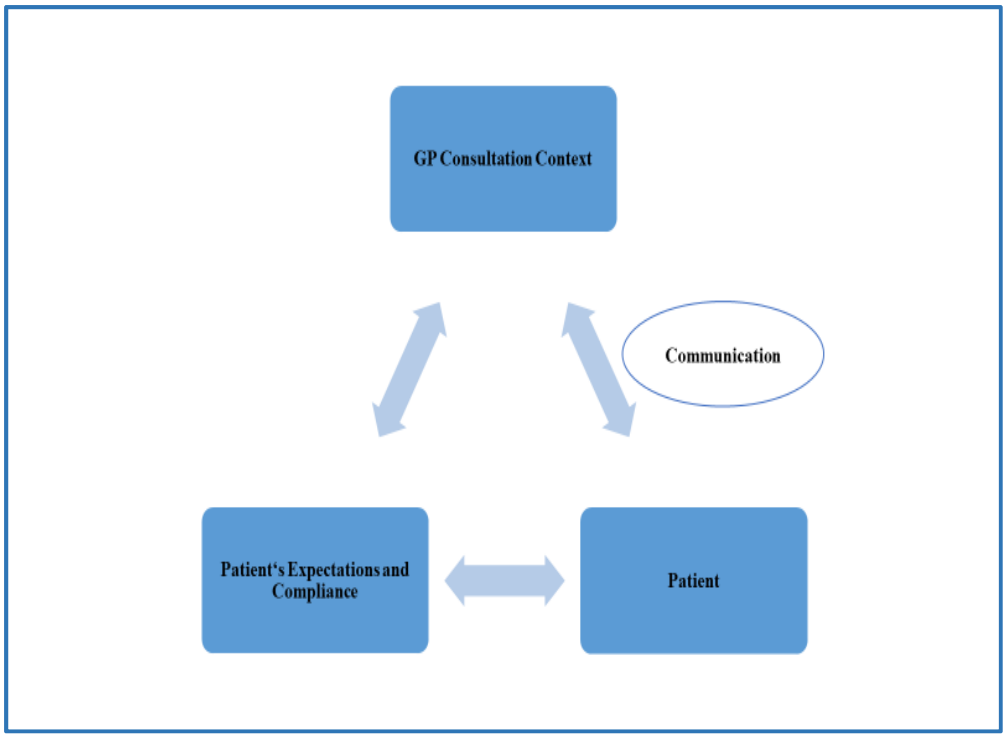

Figure 15: Consultation Cycle of General Practitioners

In the case of the general practitioners, it can be said the patient plays a very important role. In the sense, the patient's attributes, education, perception of illness, language competence, etc. have a strong impact on the communication. This, indeed, influences the patient's expectations and her compliance, which again has an impact on the consultation.

5.2.7 Phase 6. Producing the Report

This is the last phase and takes place when the themes have been fully fleshed out and titled and this phase involves detailed analysis of the data and their writing up. I have just mentioned this phase here. Based on the above illustrations in section 5.2.6, which give a broad outline of the relationships between the themes of each respective group, I have reported the findings and discussed them in detail in the subsequent chapters 6 and 7 respectively. These chapters include extracts that provide a coherent, logical and interesting account of the story the data tell – within and across themes

reinforced by vivid examples. I have attempted to go beyond the description of the data in my analysis and make arguments about the research questions answered in chapter 8.

5.3 SUBJECTIVITY

All along in the previous chapters I preferred and opted for the impersonal style of writing as well as employed the passive voice of writing in a syntactic frame. I sustained this form of writing more or less till chapter 3, the methodology section. The comparatively frequent use of the personal pronoun '**I** 'from the methodology chapter onwards denotes a breach of style.

Here I switched to the active voice, hence, using the personal pronoun '**I'**. In the initial phase when I wrote the first two chapters I de-personalised myself from the research intending to be distant and objective and situate my piece of research in a formal way. I was basically downplaying my role as a researcher and analyst at the beginning.

However, I explicate that my grasp of subjectivity evolved gradually in the course of my research. It is showing, of course, the "*being there*," the active participation in the interaction with the interview participants; the analysis process and the explaining of those findings. The transition from the "*absent self to the present-self"* Davidson (2012) has been an interesting development and progress, I went through as regards my research.

It is this interplay between researcher and participant, the creative interpretation that researchers bring to a study (Cutcliffe & MCKenna, 2004), the incorporation of personal prejudice, experience and understanding into the hermeneutic endeavour (Maggs-Rapport, 2001; Walters, 1995).

Peshkin (1988) defines **I** in the abstract to

In Search of Subjectivity – One's Own: It is no more useful for researchers to acknowledge simply that subjectivity is an invariable component of their

> *research than it is for them to assert that their ideal is to achieve objectivity… [r]eseachers should systematically seek out their subjectivity, not retrospectively when the data have been collected and the analysis is complete, but while their research is actively in progress. The purpose of doing so is to enable researchers to be aware of how their subjectivity may be shaping their inquiry and its outcomes. (p.17).*

My trajectory of subjectivity evolves from the position of a distant observer, reader to an embodied explorer participating actively with her interactants and personally integrating to understand the concepts as well as to become the co-creator of this research.

5.4 EVALUATIVE RIGOUR OF THE THEMATIC ANALYSIS PROCESS

Since reflexivity plays an important role in qualitative research, my reflexivity as a researcher and especially during the analysis process has been noted. This is mainly because as a researcher I am the co-producer of the data and I must acknowledge my part and path during the data collection and analysis period. I have kept memos in my reflective journal on each of the interviews that were conducted. The struggles, challenges and doubts I had during the thematic analysis process and in general about the six-year research I have been conducting, are narrated in my reflective journal. See excerpts of the reflective journal in section Appendices 20.

In addition, I ran several matrix queries to demonstrate the dependability and confirmability of my research work. Matrix coding queries help in the comparison of multiple nodes as a numeric table, where the number of participants referring to that respective issue becomes evident. Here quantifying responses is not the aim but confirming that the participants' views have not been misinterpreted. The following two examples of the matrix coding query I conducted on all codes of each group are illustrated in the form of a chart. An excerpt of the code patient in the form of a table

can also be found thereafter. See Table 16. Further excerpts of some themes can be found in section Appendices 21 and 22.

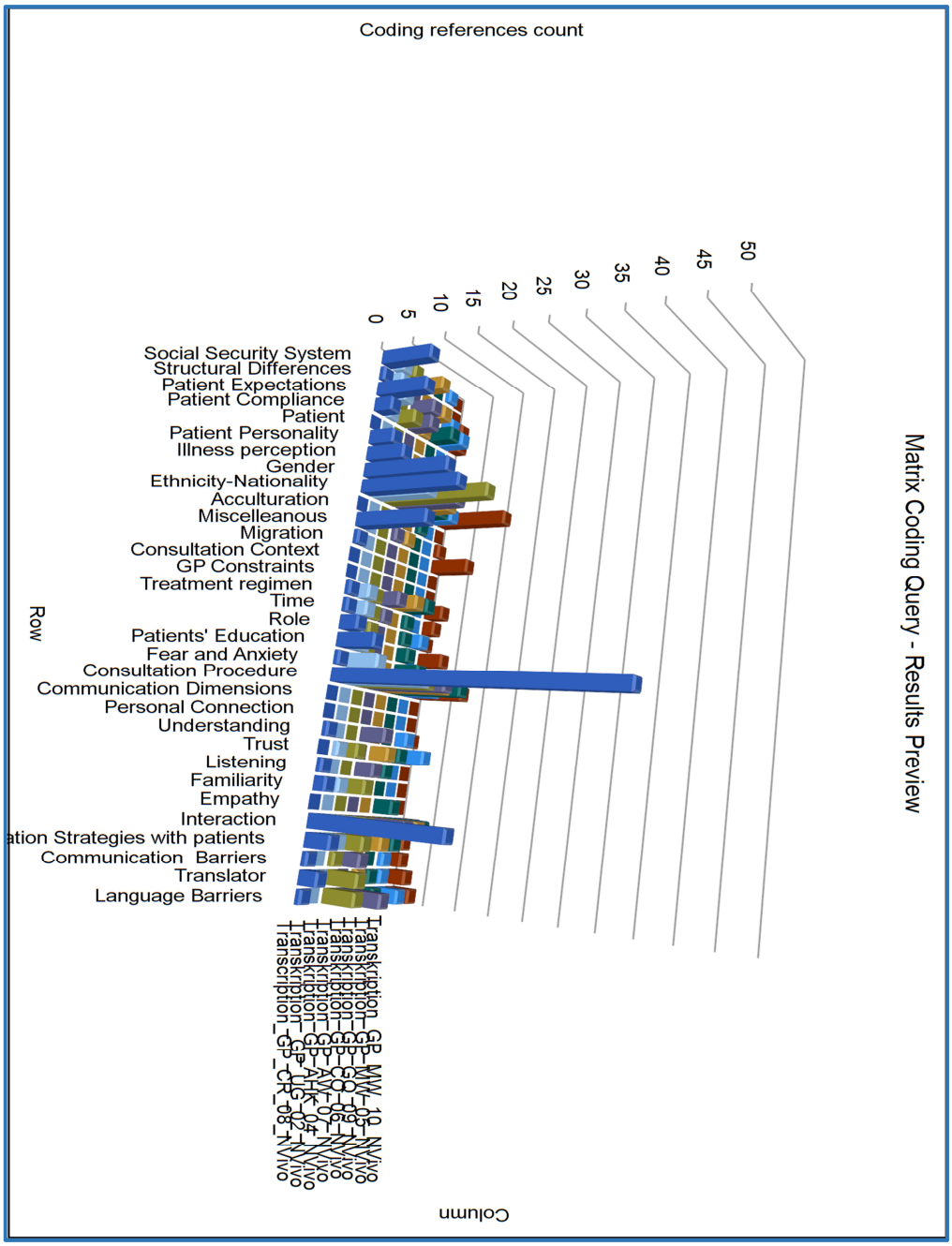

Figure 16: General Matrix Coding Query GP

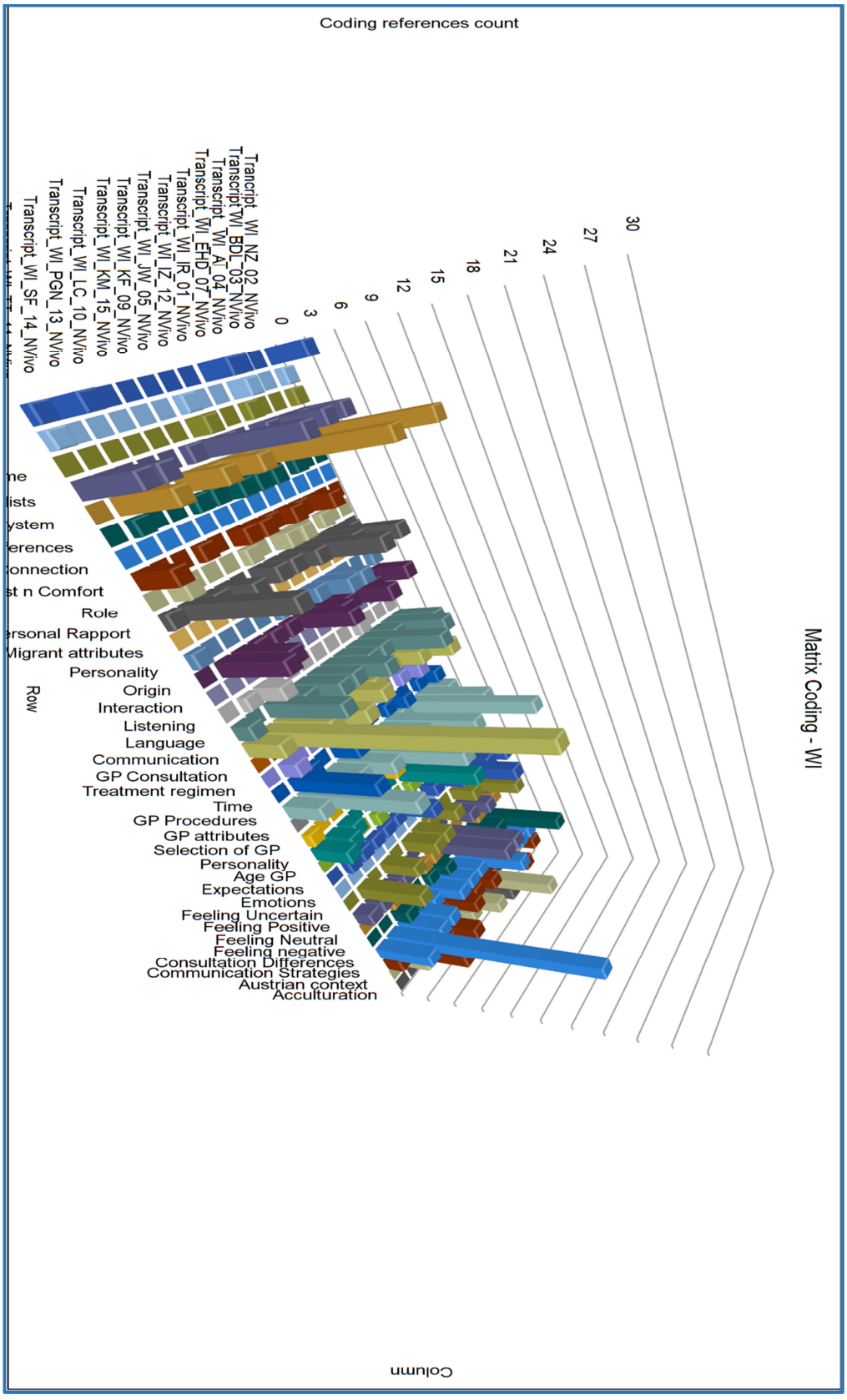

Figure 17: General Matrix Coding Query WI

	Sebastian	Susanne	Martin
1 : Patients	0	0	0
2 : Patient Personality	4	1	0
3 : Illness perception	6	1	3
4 : Gender	13	0	0
5 : Ethnicity-Nationality	15	9	16
6 : Acculturation	0	0	0

Table 16: Excerpt of Matrix Coding Query-Patient-GP

The notion of reliability is understood differently. Research must be made reliable such that you proceed systematically and all the steps of the research are made transparent to the reader and show how exactly you arrive at the conclusions (Flick, von Kardorff & Steinke, 2007). The soundness of the findings and conclusions is important to interpret the term validity in a more comprehensive way (Gibbs, 2007). I have considered alternative interpretations during the coding process and have also reached out to my research colleague again during the process of analysis.

This approach of intra-reliability was also important for an approximation of objectivity. As I conducted the entire research all by myself, I intentionally checked on the consistency of my coding every two to three days. I also requested and sought help from my research colleague to look into the coding frame to ensure that the meaning of my data is not just my understanding and thus, to avoid any kind of partiality as the material is looked into from various angles.

Furthermore, the systematic approach taken in the defining of candidate codes and subcodes; the entire thematic analysis process has been explained elaborately in this chapter. The six phases of thematic analysis which serve as a step-by-step guide as well as the Mayring and KWIC approaches have been strictly followed in the thematic analysis and coding process, accordingly.

There are four types of validity as commonly distinguished in literature: face, content, criterion and construct validity (Neuendorf, 2002). Face and content validity are the focus of qualitative research. Face validity refers to the extent to which your instrument gives the impression of measuring what it is supposed to measure;

Neuendorf (2002) describes it as "*WYSIWYG*" (what you see is what you get) validity. Content validity is assumed to present to the extent that an instrument covers all dimensions of a concept (p.115).

This is useful in data-driven coding by looking at the residual categories and seeing if too many units of coding are assigned. If too many codes have been assigned, then it is a bad sign as this means that the candidate codes have not been able to capture the meaning of the units of analysis. So, by definition when the categories of the coding frame do not cover the meaning of the material then the frame has low face validity. In the case of my so-called residual category, which is *miscellaneous* I have 4 sources and 14 references cited here. In its subcode, *migrant*, 2 sources and 7 units of coding can be found.

Additionally, I also checked each candidate code and how the units of coding are distributed across the subcodes. If a majority of units of coding were assigned to one subcode more than to the others then this would indicate that the frame is not sufficiently differentiated. High coding frequency for one subcode compared to the other is also a sign of low face validity.

This is also not the case in the codes and subcodes in both groups. The units of coding are fairly evenly distributed. For instance, with the exception of the subcode *acculturation* and further subcode *empathy* that have one reference, all other subcodes have a minimum of two references in the group general practitioners, whereas in the group of women immigrants, we can find a minimum of three references in the further subcodes *age* and *time*.

Moreover, the level of abstraction is another consideration when it comes to assessing the validity of the method. In this process material is summarised and reduced, subsequently, by categorising the material if too much information is lost, the coding frame will have low face validity. This happens when the categories or coding frames are undifferentiated. This is also not seen in the codes as they have thoroughly undergone the thematic analysis process of refining, redefining several times. The codebook also indicates the well-distinguished differentiation between codes. The

codebook and the consistent and systematic application of the codes also vouch for the reliability and credibility of the coding process.

Additionally, the use of NVivo also did not taint my research at all. I thoughtfully decided on the reasons for the use of NVivo. As mentioned in the section 5.2.3.2, NVivo gave my research structure and transparency as well as with the help of the graphical displays, not only did it provide my work a professional touch, I could also understand and explain better the salient themes that emerged; compare and create common candidate codes and common subcodes; distinguish the independent codes in both groups; as well as understand the categories in individual isolation; but also the relationships shared between the categories and gain the broader picture.

Lastly, the validity of my research is also seen in the experience of translating. Although to great extent I share a common culture with the general practitioners too based on my status as a researcher and proficiency in the German language, I could say that I have been researching from and inside the language and its community of users with my dual role as a researcher and a translator. There have indeed been situations where I had to discuss points in the text where I had to stop and think about the meaning. This occurred occasionally while translating and coding the German transcript and it was then that I reached out to my colleague for help and advice.

5.5 SUMMARY OF CHAPTER FIVE

To sum up this chapter, it can be said that in qualitative analysis, the effort of interpretation is the heart of the process and like other researchers, in a similar vein, I am interested in the real-life contexts and aim to capture as much as possible of this context through my interview participants.

This form of naturalistic research as it is carried out in a natural setting also gives emergent flexibility for, I have had the chance to adapt in view of data collection. Data analysis has been performed in an inductive data-driven way as codes and themes have

been decided upon, as the material was reviewed which means that the categories emerged from the data.

The thematic analysis process was applied to derive the candidate codes and subcodes and themes from the data. It is a dynamic, systematic and iterative process of data reduction, where, on one hand, the codes are modified; data are grouped, reorganised and linked to consolidate meaning and develop explanation and, on the other hand, thematic analysis goes beyond counting explicit words or phrases and focuses on identifying and describing both explicit and implicit ideas within the data i.e. themes. Thus, it can be said that thematic analysis is a useful method for capturing the complexities of meaning within a textual data set.

The coding frame containing the codes and subcodes, the codebook, the memos on the coding process indicate the systematic and credible procedure carried out in this research as well as support me in enabling an accurate reflection of the entire data set to provide myself as well as the readers' rich thematic descriptions. They infer true representations of the data, which means that they inform me as well as the readers of the occurrence of these specific events. Furthermore, the graphical illustrations also aid in bringing the experience into presence.

Finally, the reliability, credibility and the trustworthiness of the entire process is of underlying importance in research and these aspects have been implemented throughout the thematic analysis process.

6 Chapter Six Reporting the Findings

6.1 INTRODUCTION

This chapter describes the general themes that have emerged in both groups; it highlights the common themes; explains the similarities and differences in those themes; and also sheds light on the independent themes of both groups. Thus, the communication dimensions as well as the cultural realities that emerge have been elaborated upon.

6.2 GENERAL PRACTITIONER THEMES

A total of 16 themes emerged from the analysis of the two groups. In the case of the general practitioners, seven themes appeared. All those seven themes have been listed in Table 17 below with a brief description of the main themes, sub-themes and further sub-themes, if available. The predominant themes are typed in bold. They contain three main themes (*consultation context, communication dimensions* and *patient*), eight sub-themes (*GP constraints, consultation procedure, treatment regimen, interaction, communication barriers, personal connection, ethnicity* and *illness perception*) and one further sub-theme (*language barrier).* These themes in bold are the main focus of discussion as they strongly represent the views of the interview participants. The remaining themes while certainly important and significant factors that influence the communication process have been incorporated, but in less detail than the predominant themes. Finally, the cultural realities that appear among this group of participants are explained.

Themes	Sub Themes (if any)	Description of codes and sub themes
Social Security System	Structural Differences	Better organised translator system; less delegation appreciated.
Consultation Context	**GP Constraints** with further sub themes **Consultation Procedure,** Fear & Anxiety, Patients' Education, Role, Time, **Treatment Regimen.**	Language- extra effort, misunderstandings, hard to diagnose; translators – mainly family members; hierarchical role; less time, challenging; treatment – economical also win patients' trust. Difference between regular and new patients, western medicine has high standards, standard procedure, first vague idea then specific for diagnosis.
Communication Dimensions	**Interaction;** Communication Strategies; **Communication Barriers** with sub themes l**anguage barrier** and translators; **Personal Connection** with sub themes Empathy, Familiarity, Listening, Trust, Understanding.	Language, pictures, drawings, leading questions for explanation, no telephone translators, straight to the point. Illness perception differs, more empathy required, must draw the line; same treatment for all; more familiarity better results, come again; attentive listening; building of trust, patient centered, how one deals with patients is important, friendly, be understood.
Patient	Acculturation, **Ethnicity**, Gender; **Illness Perception,** Patients' Personality.	Need to adjust to host country; national differences; fear and pain expressed strongly, different perception of health and body functions; shy and feel ashamed to talk.
Patients' Compliance		Mutual understanding, follow up mandatory consultations in some cases, 10% show non-compliant behaviour.
Patients' Expectations		Doctor possesses magic wand, increase in demands among patients, want expensive tests, behavioral differences national.
Miscellaneous	Migration.	Political setting, gender equality, role of a woman in society, women with headscarves.

Table 17: Themes and Descriptions GP

6.3 WOMEN IMMIGRANTS THEMES

In this group, nine themes emerged. Three themes typed in bold (*communication dimensions, consultation context, emotions*) along with and eight sub-themes (*consultation differences, GP consultation, communication strategies, interaction, personal connection, origin, positive* and *negative emotions*) as well as four further sub-themes (*GP procedures, time, language barriers and rapport*) in Table 18 below, are the predominant ones here. The remaining themes have been likewise briefly explained. Here too, the main focus of this research will be based on those themes that strongly represent the views of the interview participants. Finally, the cultural realities that emerge among this group of participants are explained.

Themes	Sub Themes (if any)	Description of codes and sub themes
Social Security System	Structural Differences, Austrian context	Good hospital service, less opening hours, long waits for appointments, language issues, private and public insurance, with e-card easy, BVA more time. Good health system; scope of services is limited to time frame; traditional; conservative; not much international exposure; docs are strict, efficient and offer natural meds too (website).
Consultation Context	**Consultation Differences**; **GP Consultation** with further sub themes **GP Procedures, Time,** Treatment Regimen.	Straight forward, not many questions asked or could ask; challenging not very transparent; less time, rushedness, no follow-up questions, more assembly line; antibiotics, long treatments. Linguistic; behavioral; mannerism; tests not done; female assistant would be appreciated; time; casual relationship appreciated; no money making attitude; no pharma affiliation.
Communication Dimensions	**Communication Strategies**; **Interaction** with further sub themes **Language Barriers**, Listening; and **Personal Connection** with further sub themes **Rapport,** Role, Trust n Comfort.	Writing a script; learn to be straight to the point; translators; speak in simple German and slowly; combination of English and German; reach out with follow-up questions; non-verbal cues; clamp up; not ask for anything; rephrase when barrier. Straight forward, smooth, direct, less interest in the patient, medical jargon, no extra time to explain, dialect spoken; no patience to listen, not much attentive listening. Clinical like, more personal would be appreciated, little small talk, symmetrical role, tension in the communication; can put you to ease, non-verbal cues appreciated, more conversation appreciated.
Emotions	**Positive,** Negative, **Uncertain,** Neutral.	Polite, friendly, answer all questions, conversant; anxious, dismissive attitude, unprofessional remarks; friendly, satisfactory.
GP Attributes	Age, Personality, Selection of GP	Younger GPs are better in English; task oriented, professional, efficient, friendly; selection due to family and proximity.
Immigrant Attributes	**Origin,** Personality	Connections in home country, more CRM appreciated, more health conscious; more personal space; shy, open minded, flexible.
Patients' Expectations		Preventive actions, answers all questions; friendly; more interest in you as a person; stereotyping not nice; not to feel pushed, limited or threatened, puts you at ease, proper checks.
Acculturation		Adjustment to structural aspects; behavioural; adjustment strategies.
Specialists	Experience with specialists, Time, Trust	Procedural differences; Take their time; charges for tests.

Table 18: Themes and Descriptions WI

6.4 COMMON AND INDEPENDENT THEMES IN BOTH GROUPS GP AND WI

I have conceptualised the following Figure 18 to show the common themes that have emerged from both groups as well as the independent themes and sub-themes in both groups. I define common themes as themes, which raise similar views in both participant groups. There are not only commonalities but also differences in perspectives of both groups detected in these common themes and common sub-themes.

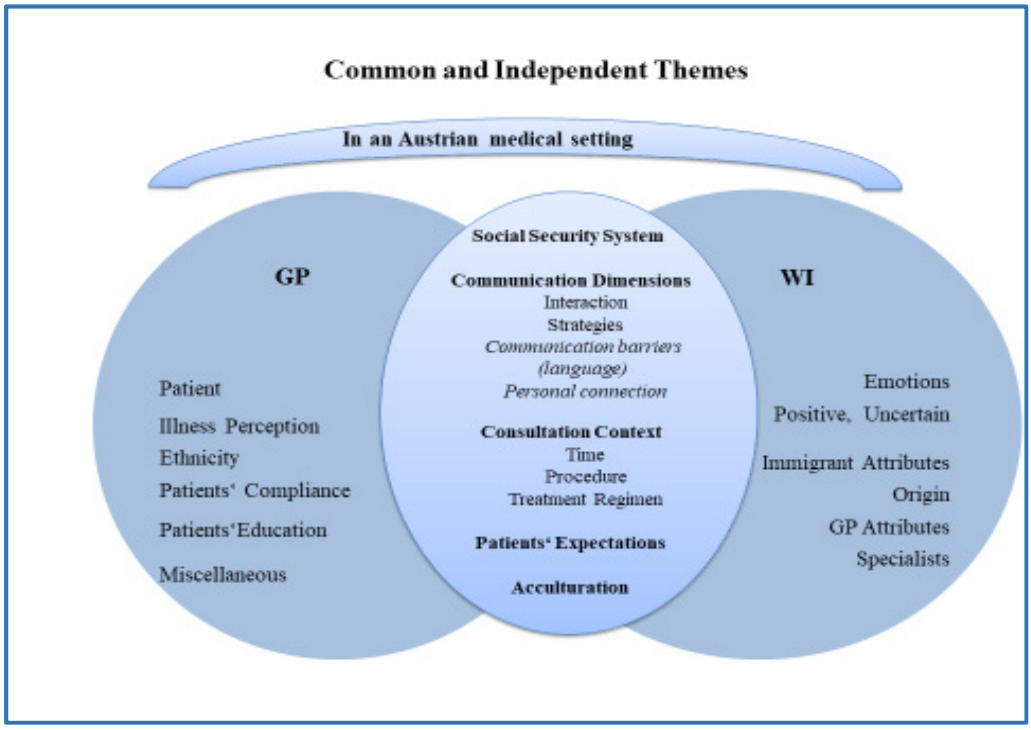

Figure 18: Common and Independent Themes

Referring to the diagram the middle circle contains the common themes such as *social security system*, *communication dimensions* with respective sub-themes like *interaction*, *communication strategies*, *linguistic barriers* and *personal connection*, *consultation context* with related sub-themes such as *time*, *procedure* and *treatment regimen*, *patient expectations*, and *acculturation*.

In addition, in the circle titled GP, the independent themes involve themes where there are no commonalities. These themes are *patient* with sub-themes *illness perception* and *ethnicity*, *patients' compliance*, *miscellaneous* and further sub-theme *patients' education* that belongs to the main theme *consultation context* which will be elaborated upon. As regards the sub-themes, I have decided to explain in detail the above-mentioned sub-themes as they were the most predominant sub-themes. The remaining sub-themes such as *gender* and *patients' personality*, further sub-themes *fear and anxiety* and *role* have been described in brief. Furthermore, the independent theme *miscellaneous* will not be referred to as explained in section 5.2.3.1. In the circle named WI, the independent themes such as *emotions, immigrant and GP attributes* will be explained in detail, too. The independent theme *specialists* in this group will not be dealt with as reasoned in section 5.2.3.1.

I have started off with a brief description of the two groups of participants i.e. the attributes and comparison of both groups. These attributes appeared as independent themes in the group WI as listed in Table 18 and Figure 18. Next, followed by the common and the independent themes to portray a better understanding of the groups' cultural realities, their strategies and challenges in the small culture - the medical consultation.

6.4.1 Background Description and Comparison of the Participants

6.4.1.1 Immigrant Attributes

The 13 interviews conducted with women immigrants represent a diversity of nationalities as seen in Table 7 and Table 9. All the women immigrants are educated and most of them are working professionals. They are recent immigrants, who have been living in Austria for less than 10 years. All of them have willingly moved to Austria owing to personal or family reasons. They are proficient in English despite English not being their native language in some cases. Moreover, proficiency in the German language is also not given in many cases, however, it must be mentioned that the German skills of these women immigrants have improved over the years.

In view of the medical consultation, the women immigrants compare their medical encounters in Austria with those in their countries of origin. They see several differences such as being raised in their home country to be more empowered to make proper choices; being encouraged to ask more questions.

Isha says, "I don't know if this is the cultural background but I felt like in Canada we were really encouraged to always ask twice and go see a different doctor and kind of be in charge of your health, so health promotion is a big thing in Canada and you are really, (ahm) encouraged to feel empowered to make (ah) proper choices."

Many are also accustomed to a different form of communication such as more open questions and follow-up questions; more information exchange and issues covered in the same amount of time back home, and in establishing a personal connection.

Prisca reveals, "Or if I'm sick while I'm in the Bahamas and she's very like, I feel like she's efficient but when she's in the room with me I don't feel stressed? I really feel like there's time and space for me to talk as long as I want and then I think its maybe also the types of questions that I get asked. You know that are a little but more open ended perhaps or follow up questions to what I say?"

She adds, "It's very important even when you meet someone for the first time right that you take a little bit of time to establish you know, it's like that small talk thing and they stick at small talk over here, we know this. It's like just to establish some sort of connection, right?"

Indeed, the personality of the immigrants also plays a role. The participants have varied personalities. Some are shy in nature to ask questions, whereas some wish to ask but do not seem to get the opportunity to do so; hence, are quite sceptical and do not fully trust the diagnosis; some, on the other hand, take a proactive step and inform their general practitioner about their medical issues.

Tamara says, "No, personally not because I'm kind of carry responsibility for myself, (yeah) absolutely. And (uh) (clears throat) I've kind of take responsibility to get my message through, so."

In a nutshell, this group of participants are educated women immigrants, who are working professionals and have been living in Austria for not more than 10 years. They are accustomed to different health care systems; their general attitude towards

health issues and medical encounters differ. Their ways of communication also vary and their personalities also play an influential role in the communication. All these factors distinctly mark the differences and challenges they perceive as well as the diverse strategies they use to aim at a successful consultation.

6.4.1.2 GP Attributes

There were 9 interviews conducted with the general practitioners located in Innsbruck and on the periphery of Innsbruck as seen in Table 8 and Table 10. These participants have been practicising their medical profession for years. They have experience in dealing and treating patients from diverse backgrounds. Although they speak English, in some cases several other languages too, the women immigrants are of the impression that the younger general practitioners are more versant in English than the older ones.

Dana informs, "So (pause) in general the impression that I've got is the younger the doctor is here the better chances I have of being able to engage with them in either language, German or English."

However, the older ones seem to be more knowledgeable; nice, friendly and helpful and represent a professional demeanor. Some women immigrants would appreciate when the doctors would have more international exposure; moreover, some also enjoy the open-minded and accommodating approach of their general practitioner towards medications.

Linda hopes, "Hey if you did doctors without borders or you were a nurse on an aeroplane, I don't know working for an airport, something like this, or a red cross or an emergency organization, it could really expand one's horizons."

Samantha explains, "(umm) I have the feeling that she's very (mm) open to, not only to hear what I have or why I'm there but she's also open for questions or if I don't understand something she is more than happy to explain one more time, or if I, I don't usually like to take a lot of medication so I'm usually asking her if I can do something alternative either therapy or, she's very open to non-standard (laughs) …and (yeah) I think that's mostly the feeling, that I can talk to her and she listens not only to the main things but everything. If I say I'm not comforTable with medication she's willing to change, she's not so hard headed."

In a nutshell, this group of participants, the general practitioners are in the medical profession for years and are experienced in treating patients of diverse backgrounds. They speak English and other languages. Despite their language proficiency, some of the women immigrants would in general appreciate Austrian doctors having more international exposure in their medical careers. The women immigrants feel that the doctors demonstrate more knowledge and experience as well as share a broadminded attitude towards different medications. Despite these aspects, based on the doctors' view, it can be said that the doctors face several challenges and employ diverse strategies to aim at a successful consultation.

In conclusion, it can be said that both groups of participants have their commonalities within their respective groups like being educated, working professionals, experience in treating patients from diverse backgrounds, etc., but at the same time differences in their perceptions, perspectives, personalities, etc., also come to light within their participant groups.

6.4.2 Common Themes

As mentioned earlier in section 6.4, commonalities, as well as differences, are found in the common themes have been discussed here. I have expressed the commonalities first and then focused on the differences. Moreover, as the entire research is conducted in an Austrian medical setting, I feel it is important to understand the context in which the research takes place, at the same time I have explained the views of the general practitioners and women immigrants who have commented on the *social security system* which is also a common theme.

6.4.2.1 Austrian Social Security System

The Austrian Social Security System covers the healthcare, unemployment and social benefits Austrian inhabitants are entitled to. A proportionate percentage of the income earned is deducted and collected by this system. As regards healthcare which is

the focus here, several governmental insurance companies operate under the umbrella of the social security system providing their multifaceted services to all inhabitants.

Each inhabitant is compulsorily assigned to a particular insurance company depending on the company or organisation s/he works for. For example, the biggest and most common insurance company in the Tyrol is the TGKK (Tiroler Gebietskrankenkasse), which provides medical coverage to employees from the corporate world, social and non-profit organisations, some universities, etc. There are other insurance companies for entrepreneurs, for governmental services, etc.

All insurance companies cover visits to the general practitioners and some specialists, hospital stays, operations as well as medicines in some cases, too. Over and above the coverage mandatorily provided by these insurances, each individual can also purchase private insurances. All women immigrants, who I interviewed in my study, are covered by the TGKK insurance.

All general practitioners have a contract with the insurance companies and predominantly with the TGKK. However, some doctors also opt out from the TGKK, sign up with only selective insurance companies or are fully private. All general practitioners are paid a capitation fee i.e. a stipulated amount for every patient they see, this fee naturally varies depending upon the insurance company. Moreover, the capitation fee paid by the insurance is also capped to a certain amount per month. Various tests and screenings are fully covered by the TGKK insurance, in fact, the general practitioners are also paid extra for certain tests undertaken such as the annual physical examination. All general practitioners referred to in my study have contracts with the TGKK.

Patients' wellbeing is an important aspect for the system. For instance, in the case of patients, who do not speak German well, interpretation services are provided by and at the hospital. These services are free-of-charge. Sometimes, social organisations also come up for the expenses of such services like hiring of interpreters to accompany patients to their doctors. The general practitioners can also call for interpreters from the hospital. They could also make use of virtual interpretation services provided by the

hospital, but by and large they tend request their patients to make the necessary arrangements.

Although patient wellbeing is the most important aspect in healthcare, the doctors are urged to be economical in their referrals for tests or to specialists. According to Susanne, the Austrian healthcare system is considered to be excellent, people from other parts of the EU even come and get screenings, etc. done here due to long waits in their respective countries (Susanne, personal communication, July 27, 2017). In general, the principles of equality and equity are strongly advocated by the system and its providers, in this case, the general practitioners, who give their best in providing good healthcare to all their patients.

As mentioned earlier, all the women immigrants interviewed are covered by the TGKK insurance, the largest insurance company in this region. They all speak in praise of the system to a great extent, however, for example, Isha feels that it is still *"traditional and conservative"* in nature (Isha, personal communication, April 07, 2017). The patients do not have much choice in the selection of general practitioners, for example, less doctors are originating from different ethnicities, although the number is gradually increasing.

Moreover, different forms of medicines such as alternative medicines like Ayurveda, homeopathy or TCM are not covered by the insurances and patients need to pay for such treatment when offered by the general practitioners (Isha, personal communication, April 07, 2017).

The healthcare system is per se a very good system with excellent provisions and care services for the people. With minimal insurance contributions too, which is affordable to everybody, each individual is insured and this gives people a safe and secure feeling when it comes to health treatment. However, there are several limitations.

According to Michael, from the structural point of view, a general practitioner is responsible for the provision of primary care, *"the entry point or the gatekeeper"* (Michael, personal communication, January 22, 2018).

The women immigrants, on the other hand, feel that from the structural point of view there is easy accessibility to doctors, specialists and hospitals with the help of the e-card. However, in the case of emergencies, they have to go to the ER at the hospital, there are no walk-in clinics nor are the general practitioners available late evenings nor on weekends which can be quite frustrating.

Isha remarks, "In the beginning I was definitely very frustrated about the fact that I couldn't see a doctor when I wanted, (ahm) for example, ah, when you know when you have something urgent, like an infection, like a bladder infection for example, something that is causing you a lot of pain and you (interior) allowed to go see a gynecologist and just wait there, right, as a walk-in clinic."

Letizia joins, "This may be the biggest problem I have here with doctors in general… GPs in particular… because they only work in the morning and I work in the morning, so it."

Linda adds, "I know they're strict [here] and in America nothing like that would happen, it's just, I don't know. Everything is just open 24/7."

Another limitation is the time factor. The health care system network is well equipped with sophisticated technology and processes such as immediate transmission of x-ray results and screenings to the respective general practitioner to expedite processes, however, despite technical efficiency; time is a hindrance due to the structural issues such as the limited capitation fee.

Sebastian admits, "The practice of a general practitioner is also a business, and we have to make profit, the capitation fee actually does not include, what would be essential, time, you know that, you might even have known it before you arrived here. In a general practice, and also in a hospital, like we have got here, a lot of misunderstandings occur, just because there is not enough time. A lot of things go wrong, because nobody takes time to structure and clarify all those pathways. Exactly."

Susanne feels, "But it takes time, which is not appreciated in our system (silence), which is an issue in general medicine and in hospitals, because not enough time is taken. (silence) But this is well invested time, because the compliance of the patient is better, and it leads to better success. Concerning compliance, one can reach better compliance solely through taking time, communication and taking care of them. They should get the feeling that I care about them."

Despite the efforts taken by the general practitioners to fight against time constraints, a few women immigrants get the feeling that they do not get the checkup they are used to.

Prisca complains, "I still don't get the general check, like she still doesn't take my blood pressure or really listen to my lungs or anything but she does take time to ask me like how I'm doing and she does always offer me several solutions which I really like… […] and I feel like there's a little more space at least with her, you know if I would ask her to take my blood pressure she would but it's weird to have to ask" (laughs).

Nonetheless, the high standards and no additional charges for treatments, subsidised medications, just hospital stay charges are well-acknowledged and appreciated by the women immigrants.

*Ramona explains, "So in Russia you also get like probably the same (uhh) but you need to pay for it, so it's always extra charge. Like here it's, it's like a standard that was really good. Um what **I** like that (uh) the doctors could speak English. What here you get with receipt (prescription), in Russia you can buy free."*

Thus, it can be said that the Austrian social security system is well accepted by its inhabitants and appreciated for the coverage offered to all insurers. There are various state insurances and depending on the employment, the employees are covered by state insurance. State insurance is compulsory to all inhabitants. The doctors receive a capitation fee for all patients they serve. They also get additional money for specific check-up such as the annual physical. The system also has its downsides such as structural and time limitations, which is not up to the satisfaction of both participants like Sebastian and Prisca for instance.

6.4.2.2 Communication Dimensions

Communication dimensions is a common main theme that covers the sub-themes the *interaction* per se between the two participants; *communication strategies* both general practitioners and women immigrants employ during their interaction, the *communication barriers* such as *language* (a further sub-theme) and the *personal connection* between the two interactants.

6.4.2.2.1 Interaction

The sub-theme *interaction* refers to the communication between the two participants. During the consultation, language undoubtedly plays a vital role in the communication process. When German language is an issue, then the doctors switch to English. The general practitioners make the effort of explaining the illness with the help of drawings or by showing the patients' pictures. When asked how they communicated with their patients.

Susanne mentions, "Precisely, drawings, for example, work well too. In order to make medical content more clear, I have books from the field of popular science, as well as photographs or drawings have been a very good aid to be able to explain what was wrong."

In line with verbal communication, the general practitioners can gauge their patient's personalities and are sensitised in the manner they put the message across.

Jacqueline gathers, "From my point of view it is important to understand, how much truth a patient can bear, and sometimes you have to talk 'German' - bluntly to them. One has to say, it is like this, and one can't whitewash it. And with other patients you have to be more careful, you have to beat around the bush, you can't be that direct, although I rather prefer a direct way of communication because it is important, and the patient has the right to get the information. Whether it is difficult or easy, one always finds the right ways for it."

Furthermore, when it comes to eliciting information from patients, some general practitioners repeat and reconfirm with the patients the symptoms and ask their patients if they have understood them right, whereas some use closed questions to affirm their diagnosis.

Matthias outlines, "As you examine, I want to say, one has to check constantly, I have to be sure. I could ask, did you understand; but this is the worst question. Better is: I have noticed this and that, did you notice the same? Is it what you perceive? Is it why you came to see me?"

Michael declares, "Under certain circumstances, I do ask more specific questions.'Do you suffer from?' More closed questions. Not really open questions, more like yes or no questions, and one hopes the patient does understand."

To a great extent, they also pay attention to the non-verbal cues, as at times the non-verbal cues help in detecting where the pain lies.

Michael explains, "Cough or sneezes can be imitated or can be pointed out to with non-verbal cues. The same with yes/no by nodding. This is certainly not optimal but often it is the only resort to understand the medical history."

Matthias states, "In principal two. The first one, listening, secondly, asking questions, and of course, both of them are not limited to verbal communication, they include a lot of non-verbal aspects as well. For example, I immediately know, if one grimaces with pain, even if it is not verbalised. or, you don't need much verbal communication rather a non-verbal one, when pain is being noticed during an examination. Non-verbal communication includes a lot, like happiness, fear, worries - and one could signal in a non-verbal way, whether the gist of a matter is on the Table or there is a hedging around a subject. I think that's of extreme importance, and it happens. Listening, asking questions, replying, physical examination, observing, touching and all the other possibilities the medicine provides."

In most cases, the questions asked by the general practitioners or the preferred form of interaction with patients is straight-to-the-point as mentioned above by Jacqueline. Nonetheless, when they have the feeling that all these efforts are in vain, then they insist on interpreters. A few general practitioners specify on their websites the languages spoken and if the patient does not speak any of these languages, they urge patients to come to their practice only with an interpreter, who may be a professional interpreter or a family member or friend, who speaks the German language well.

Jacqueline says, "I cannot afford to have an interpreter who speaks worse German or English than the patient him-/herself. Thus, it is a key criterion for me, as when the person does not master the language, it is as it is difficult to explain things in German to patients – even German native speakers, what one wants for them and what is good for them."

Certainly, it is hard for the doctors to track if the interpreter has transposed the message accurately. Nonetheless, they rely more on interpreters than on digital translation modes.

Jacqueline adds, "It is very simple. I tell them to come again with a translator. It is different if I notice that they even don't understand with the help of a translator, then I ask them to come with somebody who speaks German, who comprehends the matter. And recently, the practice of phone-translations came into fashion, which I nipped in the

bud immediately, because that doesn't work at all. Usually it was like this, "I call somebody, and they understand and can translate", this is not working at all. We are very creative, (laughs), but that is really not working."

On the other hand, the women immigrants, who in general, select the general practitioner in their vicinity, or to go to the general practitioner known to their family or in a few cases select them based on friends' recommendations, agree that the interaction with their general practitioner is straightforward. Almost all believe that the focus is predominantly on getting the job done, where often medical jargon is used.

Alia explains, "And everything is ok and the weather doesn't matter if good or bad and we get down straight to business. But most of the time, it's always straight to the point, why you are here and nothing more."

Although they consider their general practitioners as professional, who give appropriate responses, they still think that they are not allowed to ask many questions as the atmosphere appears rushed. This is mainly because they often face difficulties in explaining medical issues and need more time than usual in doing so, which is often not given to them.

Dana complains, "And those questions tend to be quite (ah) like just avoided after maybe one question and it's evident that I don't know very quickly how to describe it in German, even if I could get there and describe it in a different way (ähm) it doesn't feel like I'm ever given the opportunity to do so."

According to them, the GPs tend to speak in their dialect which makes it even more difficult for them to understand and they experience that the general practitioners do not always make the effort of reconfirming what is said by the patients.

Samantha mentions, "(Umm yeah) Definitely, If something was not a hundred percent clear she would ask me again, let me get this right, is this this and this, and then I will confirm or not. But usually that doesn't happen in the last few times I went. I just, (yeah) I know how to..."

Like many other participants, Lara found that the language used in the communication is very direct, too, "*straight-to-the-point*" (Lara, personal communication, February 06, 2018) and thinks this is a cultural matter as the German language is a very direct language. They also find that asking many questions is not desired, although patients

would appreciate more open-ended and follow-up questions. Moreover, they would appreciate it when their general practitioner took the initiative and posed more questions on the current health issue as well as follow-up questions on the past matters, which is often not the case.

Maya unfolds, "Maybe the only way in (ah) which I think it would differ maybe I don't ask so many questions here, and that's probably because what happens is the moment you ask too many questions sometimes the answers that you receive are not (ah), let's say relevant."

Dana reveals, "(Yeah) I think that it's really, the entire process is definitely complicated by just simply the language barrier, when I compare it to even with other doctors that I've seen here that one with my GP (ähm) (pause) but I (yeah) I do feel like (pause) if it's not clear where something's hurting or how badly something's hurting (pause) I just wonder if she should ask a bit more (laughs) about (äh) what exactly it is."

She adds, "And those questions tend to be quite (ah) like just avoided after maybe one question and it's evident that I don't know very quickly how to describe it in German, even if I could get there and describe it in a different way (ähm) it doesn't feel like I'm ever given the opportunity to do so."

Prisca complains, "(Umm) But I feel like definitely when I was with my TGKK (social insurance) GP guy they wouldn't ask, so my answer was enough or probably knows this and there was never a follow up question to go a little bit deeper or to find out a little bit more or you know even last time I noticed we tried this, did that even work or like how well did that work for you? Or should we do it again? It's just okay well we'll do this because that's what we did last time, it's not even a question as to whether or not it worked."

Furthermore, since the emphasis is on the medical issue, there is no room for small talk or open communication.

Isha feels, "The biggest issue because the transparency and the open communication is not always seen as something that is desirable."

At times they also miss attentive listening which they desire for in such moments when they are ill, there is the need for someone who listens to you.

Samantha explicates, "(Umm) I did have bad experiences also with, especially when I couldn't really speak German or when I spoke very little, I did have very (umm) weird meetings with doctors in which I wasn't sure what they wanted from me or they were, they didn't have the patience or time to listen so, but lately it works well. It works really well."

Most women immigrants found that the language barrier is a major hindrance to their interaction. Although most of the general practitioners speak English, the patients feel that general practitioners do not understand much English. In a few cases where the general practitioners are eloquent in English the interaction is smooth.

Trying to express pain and symptoms in German when ill, is a big challenge for them as they lack the specific vocabulary to describe symptoms as this is not part of their daily usage, so they do not feel comforTable in explaining health issues in German; they feel forced to communicate in a language they are not comforTable in.

Lara expands, "(Mmm, umm) I would… My German is not so good (laughs) (umm) and (uh) sometimes I would say it's a bit, I feel like, when I go to talk to them and (sighs) I feel like I'm (umm), I don't know how to put it. I would say it's more like forcing someone to communicate in a language that they're not really comforTable in."

Although most of the general practitioners make the effort and try to speak slowly, many women immigrants feel that minor misunderstandings occur, which makes them more nervous and would appreciate it when the doctors would clarify unclear information and above all, they do not have much of a context of what is expected from them and this makes the interaction a frustrating experience as they go in and out and do not ask questions and are left with no perfect German. They then reach out to using digital translators or interpreters.

Isha comments, "But that was I think part of the reason why you, I don't feel so welcome, I just really felt like you go in, you get out and just don't ask questions and especially, well having the mentality that you are allowed to ask questions but then left (incomp) up with perhaps not a perfect German, I think that creates a bit of frustration in doctors, right, because, I definitely don't feel like I was welcome there, so (laughs)."

In some cases, as mentioned earlier, where the doctors have a good command of English, the interaction is smooth. This eases the tensed atmosphere as their attempt to speak in English is appreciated and is also an enjoyable experience.

Letizia expresses, "A bit of a language barrier… I do speak German, but not dialect. He was nice enough to combine proper German and English, because again while I can speak German, I am not really that good in describing symptoms in German. So, he was nice enough to do the combination of proper German and English."

Linda reveals, "Yes, because they'll be very direct with me in a personal situation and I can easily take offence to that. You know, they'll naturally want to talk, pointing the finger and in American culture that's very direct, right? Especially when they want to speak English and they directly translate you know, "take off your clothes" you know it's just a bit much at first (laughs) and then you have to say, okay they didn't mean it directly it was just a direct translation. Especially with the finger, it's like 'Do this now", "I don't have time." (Umm) so let's just say, okay I understand what you're saying (laughs). (Yeah) so it can be a bit direct, especially direct translations but it can also be fun, you know, if you're willing to try and work with the doctor as well."

Despite the efforts of the general practitioners to be attentive and try to understand the patients non-verbal cues, one women immigrant complains that the non-verbal cues of the general practitioners do not make her feel at ease or give her the feeling of being welcomed, when there is no eye contact or friendly greeting, making it difficult for her to open up and talk freely.

Lara reveals, "I would say (umm) mostly it's language but I don't know if, because communication to me it's also the body cues and (uh) sometimes when, there was one GP, we [were] referred to and you know from the moment you enter the office and I would, I don't know if maybe its cultural but we didn't feel welcomed. I really can't explain, I don't know how to explain it but the body language speaks more and for me that's also communication."

She adds, "(Umm) It's, I would say first, I don't know if it's true but people say first impressions matter a lot and the moment I see you umm a smile would do but if you don't give me a smile, you don't even give me eye contact, I mean I enter your office and all you say is, you know you just show me with your hand like you can have a seat and then so I sit down, you barely even have contact with me and you're just, and then you just ask me "okay so, what's wrong" you know you just go straight to the point and at the moment you're asking me what's wrong you're really looking down on your notebook and trying to write things."

Hence, it can be said that the interaction, in general, is perceived as quick and straight to the point, leaving not much room for open communication despite the intended interaction of the general practitioners who ask closed questions; pay attention to non-verbal cues; are sensitised and speak accordingly or even in English, and at times seek help of interpreters.

This is mainly because women immigrants need more time than usual to express themselves in German. The interaction gets arduous and frustrating when the doctors speak in their dialect, which is hard to comprehend and when the women

immigrants do not have much of a context of what is expected from them. It is unanimously agreed that when the general practitioners are proficient in English, the interaction is effortless and easy.

6.4.2.2.2 Communication Strategies

Although communication strategies constitute interaction, I have assigned *interaction* as an individual sub theme because of the intentional strategies the interactants employ to make their communication successful.

To ensure a successful consultation, the general practitioners employ various communication strategies to build up a successful interaction. Certainly, German is the preferred language of communication for creating a mutual understanding which leads, the doctors to look for the right words and phrases to make himself/herself understood.

Sebastian explicates, "Well, I do need time, I do need the language, mutual understanding is necessary and it is the duty of the medical doctor, - and this something exciting in general medicine - finding the appropriate language, metaphors and phrases."

When speaking German becomes an issue, then the doctors try to reach out with English, in fact, Martin, one of the doctors has learned a few important Turkish words to try to communicate well with his patients.

Martin illustrates, "'Mohammed must go to the mountain' in this case I am the mountain, who learns to speak Turkish. And a strategy which I use now is my improved Turkish. It's getting better slowly (laughs). Yes, I have a Turkish German dictionary on my desk and I ask some patients with Turkish background or knowledge in the Turkish language, how I have to say it, what are the words for morning, lunch time, evening and night for example."

Some general practitioners also tend to draw or make use of pictures and illustrations to ensure that the message is understood.

Susanne informs, "Exactly, just an example, drawings work very well. In order to make specific medical conditions understood, I used books, popular scientific journals, which had nice drawings or pictures, with whom I could explain medical issues pretty well."

However, when it gets difficult to communicate, almost all the general practitioners insist on interpreters. They also make use of video Tablets with translators – the facility provided by hospitals but refuse to engage with any telephone or digital translators.

Susanne adds, "Whether it was on a ward, in an ambulatory department and in my own practice; my experience is, if there is a language barrier […] the immigrants normally come with a translator, either a husband, sons or a daughter."

Marlies describes, "We ask for a translator. Most of the times I ask for a translator, which has to come with them. Some time ago they tried online translation programs, but that does not work. We had the most colourful translations, really absurd and therefore I refused them."

There are various kinds of communication strategies that the women immigrants also apply to make the interaction beneficial. When German is spoken in the consultation, they request the doctors to speak slowly as they do not speak the language well or to speak in English. At times the interaction is also a mix of both German and English.

Letizia comments, "He was nice enough to combine proper German and English, because again while I can speak German, I am not really that good in describing symptoms in German. So, he was nice enough to do the combination of proper German and English. So, my strategy is to be as clear as possible. So, I just list the symptoms and wait to see what they have to say. But this is basically it."

Sometimes Latin words for illnesses are used by patients, too. Irrespective of the mode of the language they make a conscious effort in keeping the conversation as simple as possible; make use of gestures and examples; rephrase the sentences if they feel that they are not being understood to get their message across.

Lara discloses, "And with that I try and keep it as simple as possible. Probably I would explain more how I feel but because I can see them struggling because I requested in English, then the last thing I want is to make you go away out of your way to try and get more problem. So maybe so many things are lost in the, in translation or in the communication part but (yeah)."

Alia points out, "I use my hands, examples, words to rephrase. Or I speak English or Latin, because it is similar to Spanish."

Tamara explains, "So I make sure that we speak about the same issues though not really. I think I get my message through and so does the doctor. I make sure that he understands or she understands me. So, no really barriers in this. I can always rephrase what I mean, what I mean to say."

In cases, where medical jargon is used irrespective of the mode of language, and the terms are incomprehensible, they either reach out to the general practitioner requesting for further clarification or make a note of the word and then look it up after the consultation.

Samantha, says, "(Umm) Usually she's used to me saying something like "how do you say that?" or "what do you call when you do that and that?" so she also helps me a lot to find the correct words and once I hear them I know they're right or I know they're close enough. (laughs) so she does help me with the suggestions[...] If something was not a hundred percent clear she would ask me again, let me get this right, is this this and this, and then I will confirm or not."

Ramona narrates, "Well sometimes, like the doctors they use like their terminology and when they speak English and like when I don't know it, I don't know what they're talking about. So, I have to use a (laughs) translator. So, it just takes longer, maybe to communicate but (um yeah) I think that is only the difficult, was, I would remember, something else."

Conversely, some women immigrants like Maya take their partners or husband or friends along to the consultation, when they feel that the conversation with the general practitioner is or can be overwhelming; others clamp up and do not ask for any details and just accept "*the basic stuff*" (Maya, personal communication, August 01, 2017).

Dana laments, "I have also tried taking my Austrian husband along to help translate or advocate for me. This has had mixed results. I sense that many of my doctors were not well-prepared to deal with a family member translating for me."

Isha deems, "And I think as a migrant, this could also, I I mean for me, I have an Austrian husband, so (ahm) I think my experiences are probably a bit nicer when it comes to healthcare because I always have him to fall back on."

Maya feels, "Quite straight forward. But sometimes I find it, (ahm) let's say awkward to communicate with him more openly so I usually go in and I say whatever it is that I have to say, but it is off-putting and I tend to clamp up when I receive replies which do

not make sense to me like when someone says 'shit happens' and you don't expect that from a qualified GP."

On the other hand, a few women immigrants take upon a conscious proactive approach, where they inform their general practitioner of their allergies or they talk of the medications and their implications as regards the previous illness when they perceive that their doctor is being nescient and not eliciting adequate information from them. In a few cases, they also change their general practitioner.

Isha expresses, "So I also have seen doctors who take private insurance if I had to and I just decided to be more kind of proactive I guess in my own (ah) healthcare and ah just do research, talk to people if it was someone they could recommend, I would go, I would have to go and pay extra to get better service."

Linda admits, "(Umm) so I think catching them up is first priority, so when I reach out to them, I say "hey I have this problem" or "I'd like to update you on this". I really feel like I need to give them full, past medical history before that and then we can move forward, because I understand that they do see a lot of people. So, I reach out in terms of helping them follow up and stuff. And I sometimes think I really have to get the information out of them rather than them offering the information."

Irene adds, "Sometimes I just, (uh) I sometimes I had the feeling that I am asking the questions more than they are asking the questions and (uh) that I am sort of finding my, that I am sort of analysing myself, what they should actually do and uh this maybe because I talk too much, anyway."

Some of them go a step further by writing a script on what they would like to know and what they have as well as what kind of referral they would like; some make a list of three things to be asked and rehearse them during their wait in the general practitioner's practice; or try to catch the doctor's attention by asking questions with the hope of further clarification.

Dana speaks up, "But often what I have to do is I have to write down a script for myself what to say when I go (äh) to make sure that (ähm) she takes in everything or at least everything initially what the problem is because if I take too long to figure out to say something in German she won't continue asking questions about more specifics of whatever is going on. So (Ähm yeah) when I need something that is just very simple and straight forward it's pretty easy to get. (Ähm) (pause) like yeah I usually go with something already prepared with what to say."

Prisca explains, "Usually I'd make a list (umm) and I try to remember what are the three things, (uh) I don't usually have to go back to my list (uhh) but I have it on me just in case, (mm yeah). I try to be a little bit more direct as well. Especially when I went to my former GP, so as to not take up that much time. (Umm) sometimes I practice ahead of time too a little bit, what I want to say. I think about it while I'm in the waiting room."

Lara describes, "And I would say also when I feel like you're bit cold towards me, I try the eye contact or body language, I try and see if (umm) maybe I can ask questions so you can try and look at me or maybe that will change and maybe make the doctor probably (umm) now have a conversation with me instead of maybe having the yes, no or just direct, that is, this, the yes no answer, question and answer or I try and make, ask questions that maybe will make the doctor (umm) talk more and by talking more, probably to ease up the tension that is there."

Although various communication strategies are used by both groups to create an efficient communication in a short period, they are not always successful. Efforts are made from both ends to derive optimal results and they conduct themselves accordingly. For most of the women immigrants the consultations have been perceived as "*quick and straight forward*" and a few who are not satisfied with the communication with their general practitioners, they get their screening and seek advice from their general practitioners' in their home country in order to get a clearer picture and then request their doctors in Austria for the desired plan of action.

Dana speaks out, "(Ähm) and then I go to the States, I go to the states actually for a lot of my medical care and they tell me there's actually something wrong (laughs) and there's something that can really be done with it and so (ähm) I go find out what is really the issue there and then and take like my screenings from here to them, like my X-Rays or things. Then I come back here and can tell my GP what I need."

Thus, it can be said that diverse communication strategies like direct communication; reaffirming and clarifying health issues; speaking in a different language like English or a mix of languages such as English and German or German and Turkish; using pictures and drawings to get the message across to the patient are put into practice by the general practitioners.

The women immigrants also try to reach out to their general practitioners by requesting them for more clarification or bringing along a family member or friend if they are not very comfortable with German; they also take the initiative of asking

questions or writing and rehearsing a script with questions before they go to their doctor. Despite these endeavours from both ends to strike a balance, in some cases when the communication is not rewarding, other measures such as calling for interpreters, visiting private doctors or doctors in their country of origin are sought.

6.4.2.2.1 Communication Barriers-Language

Communication barriers i.e. linguistic barriers are a predominant sub-theme that appear in the case of general practitioners, who express language is the biggest obstacle they face. Little or no knowledge of German is the biggest challenge for them.

Matthias responds, "Well, the main thing is, I think, is the language barrier. One must try to overcome this language barrier and should also tell the patient that they are not getting any further. We will only manage to get any further when we find someone who helps us overcome our language barrier."

They argue that some of their patients in general are illiterate and this exacerbates the communication even further, making it difficult to determine accurate diagnosis despite their use of sign language or other modes of communication to transmit their message. This may also lead to misunderstandings which the doctors sometimes realise much later.

Hermann states, "Yes, in most cases it is the language, isn't it? This leads to misunderstandings as I mean something completely different than as it (message) comes across. This has and can happen. I realised that in the follow-up or next consultation that suppositories are not meant to be eaten."

In conjunction with the above statements, a few women immigrants feel that their general practitioners are very accommodating as they understand that expressing oneself in a foreign language can be a challenge, so they either try to speak slowly and clearly in German with the women immigrants or they switch to English.

Samantha informs, "It's just for me it's important that the doctor also speaks clearly, that I understand her or him and they get and try to understand me."

In some cases, the doctors also double-check the information they receive from them. Participants like Marina find that the doctors "*answered their questions in detail*" and are very satisfied with the overall communication which they define as *"good" (*Marina, personal communication, April 12, 2017).

Alia seconds, "It is a woman.....extremely nice. I guess, it really helps. You can chat freely and ask all the questions you want I always try to explain everything slowly and in a simple way. To be honest, I have made really good experiences with doctors here in the Tyrol. They are open-minded and show interest in my culture and so forth."

Letizia confirms, "Professional, organised… they explain… at least in my experience, they explain what is wrong with you, they explain exactly what to do… this I always appreciate. He asked the right questions, got the right answers and was really straight forward professional about it and making no assumptions at all. And that was good."

In a nutshell, it can be inferred that language barriers are challenging but they do not deter the general practitioners from trying other forms of communication such as sign language, translators to convey their message. Some women immigrants consider their doctors to be very accommodating and responsive to their language limitations and appreciate the work they put in to co-create effective communication. They are very content with the general communication in their medical encounters.

6.4.2.2.4 Personal Connection

Familiarity, trust, understanding, empathy and listening are dimensions of affective behaviour resulting in socioemotional or relational communication. All general practitioners believe that it is important to take patients seriously and provide equal treatment to all and that it is their primary task to listen to the patients; to examine them, and then to diagnose and prescribe the appropriate treatment. However, they also feel that when they get to know the patient better, it makes it easier to solve problems.

Sebastian informs, "And this is really nice, because we have this kind of continuity, one can observe development, it is a process of finding answers and building relationships, and the better the knowledge and the relationship, the more successful is the outcome, the results are better."

They also agree that it is important to build trust with the patients and this is carried out through friendliness and by seeing them as equals.

Hermann asserts, "Our profession is closely related to personalities. It works from the very beginning when a patient comes to see me and trusts in me, it can only get better. It also could deteriorate. Trust could change to distrust. It is bad, but it can happen. In principal, it depends on how you approach these patients. If you treat them like equals, there is no problem. If I say from the very beginning, I am the doctor and show arrogant manners, distrust will evolve immediately. One's integrity is immediately being questioned, exactly."

He adds, "Being friendly, and giving reassurance, that a patient can trust me, that's my strategy. I can reach it through my tone or maybe also due to my pre-retirement age."

Furthermore, it is important to explain matters in detail as well as to make sure that patients have understood them. However, some general practitioners feel that women immigrants require more empathy than local patients.

Marlies explains, "There is this intense need for explanations in their [immigrants] case and in some cases, it is very important for them to get further referrals."

Jacqueline comments in general on women immigrants, "(Ah), it is well known that patients with immigrant background need a different level of empathy, compared to the local population. The sensitivity, perception and the sense for illness is different. When you are aware of this, then you can show more empathy, on a sensible level. You don't have to exaggerate empathy otherwise you go nowhere. You have to stick to a clear line, and what is very important, valid both for patients with immigrant background and Austrian patients, you have to show understanding or sympathy."

In contrast, when the women immigrants were asked to elaborate on the differences in interaction they had mentioned, a majority of the women immigrants presume that there is not much rapport between them and their general practitioner. They would appreciate if their doctor would try to get the feeling of the kind of person they are; build a rapport by breaking the ice with chit chat; try to make them feel comforTable during the consultation; to connect more with them as then they are more likely to talk openly about their health issues.

Lara states, "I think the difference in, is in Kenya, when you're first seeing the doctor for the first time they're seeing you, they try to get a feeling of who you are just, you

know just build a rapport to make you feel comforTable so that you can probably open up more."

Most of the study participants report that developing a rapport is a good way of ensuring good communication and would appreciate when their general practitioners would give them more attention during the interaction and concentrate on following up on the recent past health issues, too.

Letizia remarks, "A person, you have known for years would be more familiar with you and I think, that is fine. I don't feel comforTable with this kind of doctor who is very stiff. It makes me uncomfortable. I am sick and I want a friendly face. He has a friendly face… my doctor… and I really like that. (Yeah), familiarity is a good thing."

Dana observes, "I am also not used to doctors sitting behind a desk and a computer, rather removed, which all of my GPs here have done."

Maya expresses, "Maybe it would put me more at ease and I would also be more forthcoming with my symptoms or whatever it is, because a doctor is someone that you go to because you don't know what's wrong with your body so I would expect that this person puts you at ease, well help you clinically with all the problems that is important but maybe also show a little bit more interest in you as a person, not (ah) not saying 'Don't ask me about how I work." and so but just you know ' You had this illness before, how is it now?'. So that never happens, because I believe that doctors here have a list on their computers of all illnesses that you've suffered and all the prescriptions, they give you. So maybe just follow up kind of questions if I go to them six months later on 'Hey you came here last time because you had this problem, is it resolved now, how are you feeling?' You know some kind of follow-up car, that doesn't happen right."

Moreover, some women immigrants would like to be treated more like a customer with more room for talk before they make their requests; they feel that the consultation should be more patient-centered, where more information is elicited; patients are asked if they need anything else, where the doctors attempt to establish good customer relations with their patients.

Dana explains, "(Ähm yeah) Again my inclination would be to say yes but also (ähm) I don't know if that comes out of (pause) the idea that we are also more customers in the US so there's a different (äh) level of attention and different levels of maybe yeah courtesy or politeness that's expected there as well as (pause) you (pause."

Prisca adds, "I really feel like there's time and space for me to talk as long as I want and then I think its maybe also the types of questions that I get asked. You know that are a little but more open ended perhaps or follow up questions to what I say?"

For a few like Dana, general practitioners are undoubtedly professional, quick as they want to "*make something happen*" (Dana, personal communication, June 06, 2017) but they appear insensitive as they do not focus on the person but only on the medical history and want to find a solution for the health issue.

Isha comments, "I feel if you are not their patient, they really don't want to get to know you or focus on you issues, they are just willing to prescribe whatever they need to prescribe and set you on the way."

Linda feels, "I think it's more like, get the patient in, (umm) understand them (umm) be nice to them and get them out and try to find a solution, right? Along the way, I just feel like in general it's I need to see a private doctor, to get the quality I want, that unfortunate."

Linda adds, "And I wasn't sure is this doctor prescribing things just so people can have them or does he really care. Because if he were to just prescribe me something, I would want him to know my allergies. It just seems that he was kind of, (yeah) it was more like an assembly line, right?"

Women immigrants like Lara would appreciate when their doctors invest more time in establishing a connection; in showing a more personalised approach by chatting a bit as this puts them at ease as they generally get the feeling that the doctor is "*less interested in knowing you*" (Lara, personal communication, February 06, 2018).

Prisca says, "It's very important even when you meet someone for the first time right that you take a little bit of time to establish you know, it's like that small talk thing and they stick at small talk over here, we know this. It's like just to establish some sort of connection, right?"

Lara adds, "(Yeah) I think that's a huge difference for me and, I would say (um) when a doctor tries to chat more or knowing more it makes you feel at ease. Then you would (uh) say, you would open up more I would say. But you're not so much under pressure to explain how you're feeling or depending on the diagnosis (laughs) (yeah), because I think there's some very personal, not personal but if, if it's not a common cold, if that's your problem. Let's say it's a gynecologist then for me it would be, it's a bit difficult to explain some of the things (umm)… That's how I would (uhh) give a reason for why I find it so different because cultures are different. And I think the fact that we come from different cultures mainly affects the way we communicate with each other so I tend to

think maybe 'hey, in Europe people just uh are less, I don't know if it's true but I tend to think that maybe people are less interested in knowing you.'"

Alia explains, "When you go to a doctor in Venezuela, you talk about the weather, politics and in general about a lot more other things, which interest the doctor as well as you. But here you come direct to the point. Why you are here and no small talk, we talk a bit maybe but here it is head onto the matter."

Thus, when personal being and emotions are not acknowledged, women immigrants do not feel comfortable discussing personal issues such as contraceptives or HIV tests.

Although for most of the women immigrants their doctors are more clinical – business-like; they do not discount the fact that their general practitioners are kind and nice. One women immigrant remarks that this is the nature of the doctors' profession and perhaps a way to demonstrate professionalism where the emotional aspect of the patient is not taken into account.

Linda comments, "Well they can be quite insensitive, but that's just their nature because they're professional and you're dealing with a personal situation with which the patients want you to be personal with them and care. Of course, it's a situation, maybe as a foreigner you don't have your family support system there and the doctor who's talking to you doesn't know that, right? I mean not by touching or things like that. (Umm) but more with the sensitivity to the issue. I think for some people it could be a normal case and for the doctor it could be a normal case and for the patient it could be a first-time case and they take it very personally, they feel like shame towards it, maybe they didn't inflict it upon themselves. They feel ashamed about it for some reason, I don't know why but I don't think they really take into account the emotional side of the patient as much as they should and this is honestly, I think worldwide."

Thus, doctors strive to provide equal treatment to all patients. They see the importance of trust-building through friendliness and are also convinced that women immigrants require more empathy than local women. However, women immigrants would desire more rapport; a better customer relationship, which could be built up by more small talk, follow-up questions on recent past illnesses. This personalised approach would make them feel comfortable and facilitate better communication on very personal health concerns. At the same time, doctors' unemotional behavior is reckoned to be a sign of professionalism.

6.4.2.3 Consultation Context

The common themes *consultation context* shows two different perspectives namely: *consultation constraints* and *consultation differences*. The general practitioners define issues like *time*, *procedure* and *treatment regimen* as constraints, whereas the women immigrants highlight the differences they perceive in a consultation in view of *time*, *procedure* and *treatment regimen*. They mainly compare the consultation in Austria with those experienced in their country of origin or main residence.

6.4.2.3.1 Time

Time constraints are practically experienced by all general practitioners. Some treat 80–100 patients in a day. Although they have less time, they make an effort to take more time with their patients. Often, it is a challenge and strenuous in such situations to give optimal attention and overcome linguistic barriers, in particular.

Jacqueline explains, "When I cannot determine the health problem through my questions and I can see that the patient is not feeling well and I must find the illness by talking to him/her. The person needs more time and then this is for us strenuous, no question."

Sometimes it is in the very last minute of the consultation that they discover what the "*real issue*" is or where the problem lies.

Matthias explains, "At the end of the day, it is all about finding out why a patient has come to the doctor? What is the crux of the matter? What's bothering him/her? In a five-minute interaction, this can be wrapped in the last 10 seconds, what is the real matter."

Furthermore, the women immigrants are also in line with the fact that time appears to be a major factor of restriction, as it leaves the doctors with less time to elicit detailed information. Doctors are nice and friendly in most cases, as professional as possible with the main focus on the current medical issue to extract the most out of the restricted time.

Irene informs, "So they ask how I'm here blah, blah, blah we talk about it and rather quickly and because there are always people waiting anyway and so they gave me some

pills and in some few days it was good so I never had a problem with them it was always, okay. (Yeah) it was usually very quick and (uh yeah), but they treated exactly the problem that I think there, so that was quick."

Not all participants in the group women immigrants voice explicitly on time constraints. Some women immigrants observe and express time to be a limited factor like in their countries of origin. Prisca believes that the consultations in her home country is longer despite the limited time factor. She does not get the feeling of "*snap fingers and move faster"* (Prisca, personal communication, February 08, 2018).

Ramona says, "Oh (um), He I would say so if I would go to um house doctor in Russia for example, he would take longer at the doctor. So, he would maybe, they would speak longer (laughs) or something. In Russia it's maybe that it's not so, they are like a bit slow (laughs)."

Prisca expresses, "(Umm) And I still feel like it's a lot like then in like the Bahamas and in the states and probably I don't think I spend more than twenty minutes with my GP in the Bahamas either you know. Like fifteen to twenty minutes maybe? I don't think it's much more than that but I just feel like we cover a lot more."

Some feel that a lot more is covered in that limited consultation time at home and this generally has to do with the difference in the level of courtesy, politeness. Many women immigrants have a fairly strict impression of Austrian general practitioners.

Dana supposes, "(Ähm yeah) Again my inclination would be to say yes but also (ähm) I don't know if that comes out of (pause) the idea that we are also more customers in the US so there's a different (äh) level of attention and different levels of maybe yeah courtesy or politeness that's expected there as well as (pause) you (pause)."

Therefore, despite less time, the doctors try to give optimal attention to their patients and at times it is at the very end that they can detect the medical problem. In contrast, the women immigrants see time factor as a general phenomenon, however, they gather that a lot more is discussed and covered with their general practitioners in their home countries.

6.4.2.3.2 Procedure

This common sub-theme *procedure* refers to procedural aspects. All general practitioners believe that western medicine has a high standard and mainly focus on biomedical science.

Sebastian says, "Naturally western medicine, western biomedicine has from the global perspective a very high standard."

They explain that their consultation procedure follows a standard procedure, where a patient gives his/her e-card - (the social security card) to their assistants, who punch it into the system and then verify the details of the patient. Next, when called out, the patient goes to the doctor.

Then, the doctor asks a few questions regarding the symptoms, which enables them to detect the illness. They, then, confirm their assumption as regards the diagnosis by asking specific questions. Next, they prescribe accordingly the treatment regimen - be it medicines or further referrals. This is, in general, the standard procedure which they follow for all patients irrespective of patients' background.

Martin explains, "Principally the question, the first question, why are you here, what are your complaints either in German or in English or with a translator. Then questions on allergies is very important, previous illnesses, medications taken so far, yes or no, which ones - all this needs to be written down. Next is the examination, depending on the complaints. Take temperature, examine throat, lungs or back and so on. In general all related examinations."

The doctors are convinced that diagnosis is easier with regular patients, whereas if the patient is new then they try to gather some background information on the patient's medical history before making a diagnosis.

If the patient comes from a different background and does not speak German, communication is often exacerbated and prolonged leaving them in a state of uncertainty whether the patient has understood the diagnosis or the treatment regimen. Often in such cases, the patient has to come again accompanied by someone who speaks and understands German.

Martin continues, "When it is very difficult and hard to explain the diagnosis and I have no choice, but to request the patient to come again with an interpreter. To come again for the second time with someone, where I know that the person understands what is happening."

According to the women immigrants, one of the vital differences in the consultation procedure is the role of the doctors' assistants. The assistants carry out the organisational work in the practice such as taking their data and entering the information into the electronic medical record system but they are not often seen assisting the doctor in procedures like checking the patient's vitals or doing tests.

Moreover, in most cases when the general practitioner is a male doctor, the female assistants are not around during the check-ups; at times diagnoses are determined without tests; basic checks like urine, BP or body checks are very often not done before diagnosis.

Irene describes, "Like when I go home to the doctor that knows me since years then they are trying to do every year like some general check, like a medical check. So, they take the blood they take the sample of the pee and everything and they run the tests basically but he, they never done it, never, nobody has asked me anything, never basically and (uh yeah)."

Isha explains, "you know, I don't know, just asking the basic questions and sometimes they would not even do tests like for example, (ah), I had the streptococcus and I know from Canada that usually they have to do a swap to get the, like the bacteria or whatever (incomp) and to get it confirmed and you have to take antibiotics. And, (ah), I had a few symptoms and I was sure it was strep throat and, (ah), I went to see a doctor here and I said just swop and he said no no, you don't have to do it, I mean, (yeah), so it was like (incomp) differences."

The women immigrants showed mixed reactions as regards consultation. Long endless waits till one gets to meet the doctor, but when in communication with their doctor, majority like Prisca are of the opinion that the consultation is "*straight forward, rushed"* (Prisca, personal communication, February 08, 2018), although they feel that their general practitioners are nice and professional to a great extent.

Prisca answers, "And that's after you wait an hour in the waiting room twiddling your thumbs. It's like slow, super-fast, slow."

She adds, "I do feel like (umm) like it's a bit rushed here even though I do think that (umm) they're trying to hear me out, it's never like you need to stop talking and we need to wrap it up. I never get that please stop or I don't have time for you but it's a little bit brisk brisk brisk, go go go, uh huh uh huh, type type type, okay okay, thanks thanks thanks, bye bye bye. Right?"

For some like Maya, it is a general checkup, where all the questions asked, are answered; however, for a few it is a "*get in and get out*" with no questions (Maya, personal communication, August 01, 2017), in some cases even the basic questions like "*what kind of allergies do you have?"* are not asked. General assumptions are made regarding the treatment without many conversations; no complete checkups are done, which gives participants like Dana the feeling that the "*GP cares to make something happen in 2 minutes*" (Dana, personal communication, June 06, 2017).

Dana explains, "I (ähm) get the feeling she just makes a decision for something to happen whether I need a test or not because I would usually go and you have a conversation with them but this has never really happened with my GP here. And I've often been told then from the very beginning that like it's something mental. In times when I was like okay, I understand like (laughs) psychosomatic issues are possible, but I wouldn't expect a doctor to start with that assumption."

Participants like Linda get the feeling like being "*on the assembly line*" (Linda, personal communication, February 02, 2018) as it is like get in; understand the symptoms; find a solution and get them out.

Linda adds, "And I wasn't sure is this doctor prescribing things just so people can have them or does he really care. Because if he were to just prescribe me something, I would want him to know my allergies. It just seems that he was kind of, yeah it was more like an assembly line, right?"

Hence, it can be said that the general consultation procedure demonstrates a structured agenda, which is prolonged when language barriers come into play. The interaction, in such cases, is at times difficult, lingering uncertainty among the doctors. The women immigrants, on the other hand, perceive differences in the tasks carried out by the doctor's assistants when comparing the consultation procedures. Some also feel that the consultation is quick and that the doctors solely concentrate on understanding the symptoms and finding a solution for the health issue.

6.4.2.3.3 Treatment Regimen

General practitioners try to explain the treatment they feel would be best suited for cure based on the described symptoms.

Michael elaborates, "I try to convince them with my view which is mainly arguments and explanations. Then the matter becomes clearer when one explains why and how and then the people are mostly understanding and willing to enforce it. Indeed, follow-ups are planned. One has to give the patients a plan."

At the same time, when it comes to the treatment regimen and further referrals, doctors must bear the cost factors in mind and try to be economical in their decision-making.

Michael adds, "But it is my job, and I make sure that I steer the consultation as well as prescribe economical therapies. It is not only the patient in front of me but I also bear the whole picture at the back of my mind –therapy costs, resistance situation and so on."

The treatment prescribed often does not bring about patient satisfaction as patients expect something different than what is recommended to them. General practitioners feel that patients often desire an immediate effect after their visit.

Jacqueline admits, "I always have the feeling that patients men and women but also patients with migration background feel that I am declining them a therapy when I don't prescribe antibiotics."

She adds, "I have many patients who come and want antibiotics because it is common in their countries when they go to the doctor. When I tell them that it isn't necessary then they have the feeling that they are not being treated well. This means: they want more medications than we for example, as often local inhabitants would say 'do I really need to take this, is it a must?' and they are more likely to say 'want to have.'"

At times doctors do give in to the patients' wishes such as prescribing antibiotics or screenings- and see this as a way to win the patients' trust and to calm them down.

Sebastian elucidates, "For example, x-rays. It could lead to tensions while communicating if it is denied. One has to inquire and explain, and try to ease the patient."

Most of the women immigrants confirm that their doctors are accommodating, and even prescribe alternative medicines or medicines of patients' choice. However, Maya has the impression that the treatment is unusually "*long and retracted"* (Maya, personal communication, August 01, 2017) which makes her sceptical but has helped in the long run.

Maya narrates, "But that makes me believe that if it's so long and retracted and if it's going away on its own, that means that the doctor knows what he's doing. He knows that you know, let's try out all these things."

One of the women immigrants is, in fact, delighted to see that the doctors do not have any affiliation with any pharmaceutical company and are genuinely interested in solving the problem without making any extra money. Furthermore, the patients do not feel that they are compelled to buy those products, nor do the doctors encourage the patients to undergo certain screening for which they would have to pay for. This is a very pleasant feeling for the patient as they firmly believe that the doctors are not out to make money.

Tamara informs, "(Umm) (laughs) The doctor is not just going to create some potential diseases in me in order to make some extra tests in order to make some extra money (.sic.) Oh my gosh, some honesty in the horizon."

To sum up, effective, appropriate and economical provision of treatment is aimed at by the general practitioners. At times they give in to patients' wishes to calm them down or to win their trust. On the other side, the women immigrants appreciate this responsive attitude and are also very content with the doctor's intention which is primarily cure and not money-making.

The general practitioners feel that many patients believe that the prescribed medications will show immediate improvement like Sebastian says *"a magic wand"* that leads to immediate cure (Sebastian, personal communication, February 08, 2018). Some doctors think that the immigrants expect further referrals to specialists or screenings for more clarifications than just their diagnosis.

Michael explains, "The healing process takes time. And many people think, they don't have that time. Or rather, assess themselves in a wrong way. They think, a doctor prescribes a therapy, and the following day everything should be fine. (Uh) that is not true. It takes time, it needs rest. Mostly, it is a self-healing process, but many don't like this idea, they don't want to take the time, don't want to wait. that's how I feel. They would come already after one, two or three days, because it hasn't improved."

Marlies wraps up, "They want further clarifications. They want to go to the orthopedic doctor or to be referred immediately to the hospital –they are of the opinion – it's in their heads that hospitals are better or the like."

On the other hand, for all interviewed women immigrants, the general practitioners must answer all questions. Some women immigrants are satisfied with the fact that their doctors respond in detail.

Ramona says, "(Mm) Like from him personally, (mm) (laughs) I just wanted to know I have, what medicine I get. And he like answered all, all fine."

Marina notes, "He answered to all my questions and this is (laughs) already was (laughs) enough for me, and, (ya) I feel okay and that's that, and when I have questions (uh) the doctor (uuh)… should (uuuhm) the doctor should be very careful and very friendly, in order for the patient to (uh uh uh) feel (uh) herself himself openly and to go to (uuh)… details and to talk everything openly and to not to feel herself himself limited or threat and pushed."

Conversely, a few would appreciate when their general practitioners would do their jobs well by conducting basic checkups; and would appreciate more patience and understanding as well as more explanations.

Prisca insists, "You know, because it's not my job to ask you to check me properly."

Dana reveals, "Cause I would usually go and you have a conversation with them but this has never really happened with my GP here. I would expect more patience, and yes asking more questions and more follow up questions to really actually diagnose (pause) me. Someone, who when I'm in the middle of trying to explain my issue (pause) that they would be able to sit there and wait till I finish my sentence and maybe ask more questions about it."

Moreover, a few would also want their general practitioner to show more interest in them and refrain from stereotyping; provide more information as this will make them feel at ease and open up more enabling them to talk freely about their health issues, hence, mitigating their frustration.

Maya hopes, "Maybe it would put me more at ease and I would also be more forthcoming with my symptoms or whatever it is, because a doctor is someone that you go to because you don't know what's wrong with your body so I would expect that this person puts you at ease, will help you clinically with all the problems that is important but maybe also show a little bit more interest in you as a person, not ah not saying 'Don't ask me about how I work." and so but just you know ' You had this illness before, how is it now?'"

Marina explains, "And of course, (uuh), it is kind of generally it's okay, absolutely, but it's not nice when you coming to the patient or to the doctor, (uh uh) and ooh, you are coming from poor country, you know? Such (uuh) stereotypes."

Isha concludes, "But also due to the fact that I lowered my expectations (laughing). So I no longer really expect to get (ahm) all my questions answered and I just learned to to pay for what I can get and (ahm) then perhaps look elsewhere. […] I don't really have high expectations in terms of getting I don't know, diagnosis (incomp) or even getting a lot of tests then. I just see him when I have to with the basic things and if (ah) something more drastic will happen then I guess I would be überweised (get a referral) anyway to to see someone else, the specialists."

Hence, it can be said that the general practitioners have to deal with the different expectations such as immediate cure, further referrals or screenings although at times they are not required. The women immigrants share by and large that their expectations are met, some of them anticipate more patience and understanding; some want their doctors to carry out the basic check-ups; provide them with more information and build a good rapport without biases.

6.4.2.4 Acculturation

As regards this common theme, not much has been expressed by the general practitioners and so it has been categorised as a sub-theme, in contrast to women immigrants, where it has appeared as a theme because it has been mentioned quite often.

According to a GP, women immigrants must adjust to the host country Austria when they move here to reside.

Jacqueline articulates, "I can imagine, if I would leave Austria for another country, the situation would be similar, but one has to adapt, hasn't one? That is very important, no

one can be spared from it and everyone, who lives abroad for a longer period of time - like I did - has to adapt. There is no way out of it. Even if you encapsulate yourself in your own small community, you have to adapt otherwise it won't work - independent of culture and nationality. An English person has to learn German, a Spanish as well, and it is the same for all the others."

Samantha says, "Currently, no. I would say, before in my first three- four years where I really couldn't control the communication from my side but I didn't understand or I couldn't express myself (umm) clearly but I would say (yeah). It was definitely an issue."

Letizia states, "But once I got the hang of it, it was not really problematic."

For some, it is a must to accept the differences as they live in another country and cannot expect to have things going their way. They see it as a way of integrating into the new environment.

Ramona feels, "(Umm) well I think when you're in a foreign country you need to, kind of accept it. You came, you need to integrate yourself, you need to learn and how to avoid, (uh) I don't know, maybe come with somebody."

Lara admits, "I don't get annoyed you know. As much as sometimes things don't go the way you think but, in the end, when I go home, I think '(ah) well, I'm in a different country how people communicate with each other. So just accept how it's when you go somewhere things might be different from what you're used to. (Yeah) that's all I can say. So that's how things are run' I just accept it. I don't know. (Yeah). But (yeah), I think that's all I can say. Maybe it's an excuse to accept things but I think it plays a huge role."

Alia remarks, "Hello, you are in a different country, in a different culture, you have to adapt a little bit. Not getting adapted rather being flexible. Yes, adaptation is the right word, also being open-minded, and not so...it doesn't have to be like you think it should, it is just different."

Despite trying to adjust to the current situation, it has not been successful for a few. For Dana things have "*stayed pretty much the same"* (Dana, personal communication, June 06, 2017). Some still struggle with the communication and structural issues resulting in frustration or giving in to the situation, or "*getting more numb*" (Isha, personal communication, April 04, 2017) simultaneously, making them aware of the fact that they are not from here.

Dana explains, "I would usually go and you have a conversation with them but this has never really happened with my GP here. I've definitely handled thing differently throughout my time being here and learning more what I should or should not do or (ähm) the best way to get access to the medical care. […] But like it's such a mixed bag, but I'm looking for someone (laughs) who ah yeah might handle it a little bit differently. I have spent a lot of time in the past looking for and changing doctors here, so I don't feel too hopeful and often decide it's not worth the effort."

Isha elaborates, "I think, it doesn't matter how long you've been here, oh or I don't know actually because I've only been here for seven years, so, maybe it does get really easy in the end but I think, it it really depends on your values and I think on the values your country instilled in you. I mean on one hand of course, you get more, I don't know, just get more numb I guess, when it comes to these cultural (ahm) differences but, on the other hand, you are also really aware of the fact that you are not from here."

She adds, "I mean I'm definitely more (ahm), I think adjusted here, so now I understand, because (ahm), I mean you might know, in north America, everything is open 24/7, so you can really get any type of service any day of the week and Sundays are no exceptions, so (ahm), for me in general it was a surprise that (locations) are closed here on Saturdays and Sundays including the health care or like health services ah centers. I do plan my my health visits in advance."

Thus, it can be inferred that acculturation is still quite a struggle for many women immigrants, who have been living here for 10 years or less. For some accepting the differences is a sign of integration; for some their attempts to accept have failed and still struggle with the communication and structural issues; and some develop an indifferent attitude towards that issue, whereas one general practitioner feels that adapting to a new environment is the key to successful functioning.

6.4.3 Independent Themes in Group GP

The independent themes are stand-alone themes so to say. They are different from the group women immigrant and do not share any common perspectives with that group. They are as follows: *patient* with sub-themes *illness perception and ethnicity*, *patient compliance*, and further sub-theme *GP role*. These independent themes are depicted in Figure 18 as they are the predominant themes and sub-themes that appeared. The remaining sub-themes like *gender* and *patients' personality* and further sub-theme *fear & anxiety* are not mentioned in Figure 18 because they are not dominant themes,

nevertheless, they have also been briefly incorporated in this section. The independent theme *miscellaneous* will not be addressed as mentioned earlier in section 6.4.

6.4.3.1 Patients

In most practices, the ratio of patients is 1:1 i.e. 50% locals and 50% immigrants. When the general practitioners address differences they experience between patients from the majority population and patients from the minority population, they all refer to the national identity of the patients. They tend to categorise their patients based on their country of origin.

Matthias informs, "Firstly, I think that they know of more possibilities in their home country. I have the impression that in Syria before the war, they had a very good health care system. You can see that because the people are well groomed and have good repaired teeth. They've undergone many check-ups, have a good vaccination status. You can recognise where they come from. An Afghan and a Syrian are poles apart. The Syrian, who lived in a country which 10 years ago was flourishing, and had a good medical infrastructure, has other expectations than someone originating from Afghanistan or even Africa. You notice that."

Furthermore, they feel that the perception of health and body functions is culturally influenced.

Matthias expresses, "Each individual has his/her unique concept of health, illness, body and body functions, their importance. This exists and in the different cultural areas, one has a different approach to health and illness independent of the diagnosis and therapy possibilities; but they are health matters, which are connected to values and ideals; connected to the concept of body and the functions of the body."

Moreover, some general practitioners feel that the patient's personality also plays a role as women immigrants are said to be shy in talking about their symptoms. Nonetheless, women are able to articulate better about their bodies and related issues than men (Marlies, personal communication, February 19, 2018).

Hermann states, "It's clear and logical, the patient doesn't have the courage to say something, loss of face or whatever and then they fall ill. From the organisational perspective, it is simply difficult."

Marlies asserts, "But women are easier. Women, in our and in other cultural environments, can handle with their bodies better, they can articulate better when it comes to related issues – and this is a very important factor – and it does not matter if the woman is an immigrant or a refugee, it's all the same."

Some general practitioners explain that women immigrants express fear and pain very strongly, whereas some patients do not express emotional pain very comfortably so it is often done in the context of physical pain.

Jacqueline says, "When I am administering an infusion, draw blood and remover stitches everywhere where one has to work with the patient hands on, their perception is different, strong and that is also communicated also acoustically."

Martin assumes, "At times, partly a bit exaggerated, when one examines a patient, there seems to be this unspecific muscle pain."

Moreover, they also sense fear in the patients. It is this fear towards the unknown, the treatment and so on that many women immigrants show anxiety and angst. In such cases, they try to explain more and take away those fears to facilitate better treatment.

Susanne expresses, "I always had this feeling, wouldn't it be better if I was kind of a shaman (short pause) in order to get rid of the wall of fear which I sensed in our interaction – in our first clinical encounter. So, when you don't know someone and he/she represents another culture and the person has something that makes him/her ill and that brings about angst. Then as a doctor you sense a certain barrier towards this person and this is mainly fear related."

Thus, persons originating from a different country constitute 50% of the patient population and are distinguished based on their national identity. According to the doctors, patients' perception of health and illness is cultural-bound. They also feel that in general, women immigrants differ considerably in nature. Some are often said to be shy in talking about their symptoms, but articulate better than men on health-related issues. Some are also highly expressive when it comes to pain and anxiety. Some require more explanations from doctors to take away their angst.

6.4.3.2 Patients' Compliance

Patient compliance is an important aspect and this generally occurs when the patients' expectations are met in an interaction. When the patients leave the doctor's practice with the feeling that they have been understood and the doctor's reaction has also been appropriate and meet the patients' expectations, then it can be defined as a successful interaction and patient compliance may be anticipated.

Matthias describes, "At the end of a consultation the patient should have got the feeling that he/she has been understood and that the intervention of the doctor was adequate. This is what I expected and (ah) – that was the reason why I went to the doctor. And from the doctor's perspective, I could meet the patients' expectations, that's why the patient came to see me, these were the expectations, and I could fulfil them with the help of science. If you would interview both of them and both tell the same, then I would consider it to be a successful interaction."

Depending on the health issue, follow-up consultations are a must for some patients and the rate of adherence in such cases is quite high.

Martin explains, "As I see patients when they are sick and I have to prescribe sick-leave, and I tell them to see me again in one week's time. They have to do that otherwise they would have problems with the health insurance and I have to certify that they are healthy again. So insofar there is no problem with the follow up."

In general, Marlies discerns that about 10% demonstrate non-compliant behaviour (Marlies, personal communication, February 19, 2018). Some general practitioners are convinced that only one-third of the patients follow the treatment and it is the patients' responsibility to follow the prescribed medications or treatments.

Jacqueline states, "If a patient leaves happy with the feeling that s/he has been understood, and is compliant. The patient is going to follow the instructions. It is widely known, that about one-third of the patients, don't even collect the prescribed medicine from the pharmacy. The second-third, picks the medication up, and only the last-third (laughs) takes it. It is pretty difficult."

General practitioners like Sebastian feel that when he actively listens to patients, they feel that their concerns are taken seriously. When he takes the time to build a relationship with his patients by involving them in the decision-making process

and not simply ordering them to follow his instructions, then *"mutual understanding"* is created (Sebastian, personal communication, February 08, 2018), and the patients will follow the treatment.

Jacqueline adds, "I did notice they like to come if they have got the feeling that they are being taken seriously, that, despite their ailments, they are being taken seriously, even if it is a bagatelle quite often."

Michael joins, "I mentioned at the beginning, that one has to create a relationship based on trust. Nowadays, you don't tell the patient anymore, you must do what I say, that is the past."

Martin concludes, "I can't stand next to each patient, with a gun in my hand, telling, either you take the medicine or I'll shoot you that is not possible, I can only make suggestions and tell them that the Tablets will do them good. And when they don't follow, then they don't."

Thus, it can be summed up that patient satisfaction is given when their expectations are met, subsequently, compliance may be anticipated. Although some general practitioners believe that 10% of the patients show non-compliance, others are of the opinion that the rate of adherence can be increased through active listening, rapport building, and by involving patients in decision-making.

6.4.3.3 GP Role

The general practitioners portray a varied picture of their roles: hierarchical at times; in some cases, as an information and service provider to whom patients come and assert their demands; someone who patients can trust; someone who gives them an honest opinion, and sometimes as managers. Their roles are personality-oriented as one of the doctor states.

Hermann states, "(Yeah), Over time it has increased isn't it? Our job is extremely personality- oriented."

Martin thinks, "It has changed now with the local population. The doctor has become more of a service provider, as per the motto – the patient goes to the doctor and says. 'I'd like to have this and this from you.'"

Jacqueline perceives, "An important role, as an information provider, as a person who you can trust, isn't it? Because they come and want to get an honest opinion."

Thus, it can be said that they see their role as experts, as managers, information and service providers. For the women immigrants, on the other hand, the relationship between the doctor and the patient is also an important factor in a medical encounter. In most cases, Linda and many others define it as symmetrical in nature, where they have the feeling of "*being treated as equals*" (Linda, personal communication, February 05, 2018).

6.4.4 Remaining Independent Theme in Group WI

The remaining independent theme *emotions*, is also a stand-alone theme different from the group general practitioners and does not share any common perspectives with that group. The other two independent themes in the group WI *immigrant attributes, GP attributes,* have already been dealt with in sections 6.4.1.1 and 6.4.1.2. respectively.

6.4.4.1 Emotions

In this research, based on my data and my coding, four kinds of emotions have been expressed by women immigrants, namely: positive, uncertainty, negative, and neutral. The first two have high prominence. The women immigrants react positively towards communication with their general practitioners, who have always been there to help and answer their questions. They feel, they can talk to him/her freely and openly; the doctors try to explain things to them in a simple manner; the combination of friendliness, willingness to provide more information; no pharmaceutical affiliation; and familiarity makes them feel relaxed and comforTable with their doctors. They trust their doctors and feel good and secure.

Marina is delighted, "Ya, it's really nice and now it's also really nice, speak freely and I'm criticising all (laughs) this uh … stuff openly and ya ooh I was only disappointed when I told her I'm not uuh … really okay uhm with this doctor."

Letizia seconds, "Because of the nature of one of my complaints with my GP… he didn't make any such assumptions at all. He just treated me like a normal human being, which again was very nice. I find that very refreshing. That was good."

Tamara adds, "It never takes too long but no matter what I said to the doctor he basically kept on asking still, some additional questions so, just in case, so I don't know. (Yeah). So good, good, very good experience".

Furthermore, a lot of the women immigrants are unsure if they are getting the same level of care as in their home country. The language barriers, time limits, the non-verbal cues give them the feeling of not being welcome; the straight-to-the-point attitude; no rapport gives them the feeling that something is missing in the interaction and are not a hundred percent sure that everything is checked in the consultation.

Linda describes, "Well I sometimes feel like it's like going to the civil servant where they're just like, either they have a good day or don't and your last name isn't going to change (laughs) unless you get married, so you're stuck with the same person."

An interesting analogy made by Linda, where she compares a visit to the general practitioner to a visit at a governmental office where one is forced to go to the person behind the counter assigned to you. In Austria, the allocation takes place alphabetically (i.e. the first alphabet of your surname) so whether you like the person or not you must deal with the government personnel unless you change your surname. Moreover, a few women immigrants like Prisca have no high expectations as they just want the basics to be done and tend to step out from the doctors with "*ah-ok feeling*" (Prisca, personal communication, February 08, 2018).

On the flip side, language barriers; not being encouraged or given the time to ask questions; getting the feeling of not been taken seriously; no personal connection; not asking basic health questions such as allergies; unprofessional responses at times; all these factors have resulted in frustrating experiences and anxiety when women immigrants do not receive the expected level of care.

Finally, some of the women immigrants feel that the visits have been quite satisfactory and state that the chances of getting misdiagnosed are still very little despite constraints. The doctors are friendly, respectful; however, cultural sensitivity would be much appreciated.

Isha claims, "I think the cultural sensitivity is something that is definitely needed in our (yeah) modern world, and I think Austria is no exception."

Therefore, it can be inferred that the four types of emotions positive, uncertainty, negative and neutral expressed by the women immigrants are triggered by various experiences made in their encounters.

6.5 CULTURAL REALITIES

In light of the detailed explanations given in the above sections on the various communication and consultation aspects, it can be said that both groups experience positive issues and challenges, which indeed vary from person to person in each group.

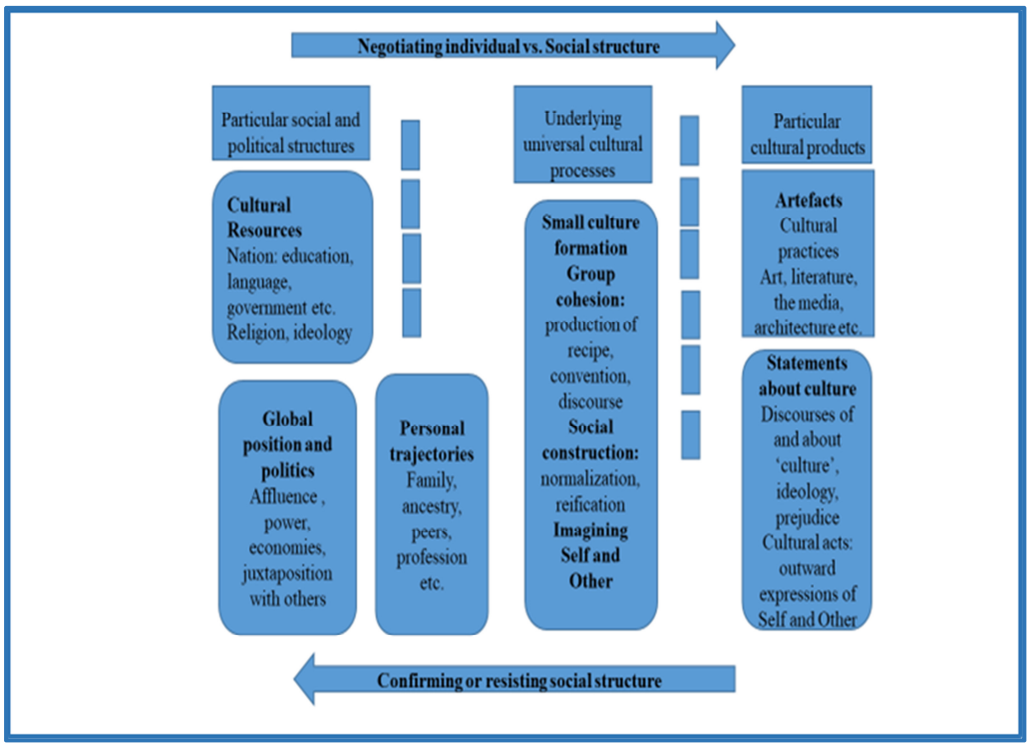

Figure 3: Aspects of Cultural Reality Source: Holliday (2011)

Referring to Figure 3 in section 2.7.1, repeated above, it can be said that both groups must deal with the wider societal influences and negotiate on an individual basis with each other in the small culture i.e. the medical consultation.

Against the backdrop of the Austrian social security system, it is determined that the system is by and large well accepted by both groups and its provisions like affordability and equity of treatment irrespective of contributions are widely acknowledged and appreciated. However, in this research, *cultural resources* like *national culture, education, language, ideologies* as well as *personal trajectories* like

personality seem to play a dominant role in shaping the cultural realities of my participants. Undoubtedly other factors like *global position and politics* also impact the consultation, however, these factors as well as the preponderance of the aforementioned *cultural resources* could not be clearly pinpointed.

Based on the overall tenor of responses, some women immigrants like Isha, Linda, Prisca strongly and Dana to some extent, romanticise aspects of their national culture i.e. North American culture as regards the structural, temporal, procedural differences. This also appears to be the case with general practitioners, who believe that the Austrian system and procedures set high standards. Despite the fact that the participants of both groups are educated persons and speak one common language i.e. English which may be their native or first language, they at times seem to have difficulties during the medical consultation.

Also, the personal trajectories and ideologies of the participants affect the medical consultation. For instance, the individual personalities influence the situation as some women immigrants are more reserved and refrain from asking questions, whereas some are proactive and determined to get responses. Likewise, the general practitioners see themselves as information and service providers or as managers. Some doctors like Matthias also tend to identify their patients based on their national identity and some doctors feel that the patient's gender also influences the consultation. For example, Marlies and Hermann feel that women immigrants are shy in nature but can articulate health-related issues well. Other doctors like Martin and Jacqueline sense fear among women immigrants during consultations and feel that they exaggerate pain.

All these aspects mentioned above shape the cultural realities of my participants and, in turn, the underlying universal cultural processes that they bring in during the small culture formation i.e. the medical consultation. The existing structure of a medical consultation as illustrated in Figure 4 section 2.7.2, repeated below shows that the medical consultation seeks group cohesion through convention, discourse to achieve the intended aim of successful consultation.

Conventions like time constraints due to the high workload of the doctors makes it difficult for them at times to strike a balance. The consultation procedure is fairly standardised and more or less repudiates any other approach besides biomedical credo. The main intent of good equal treatment is given but at the same time it should be cost-effective. In view of discourse the consultation is very direct and plain-dealing in nature leaving barely any room for trivial conversation and pleasantries. Also, misunderstandings occur due to language barriers or use of dialect, which, in some cases, result in frustration among some women immigrants like Marina, Isha and Maya.

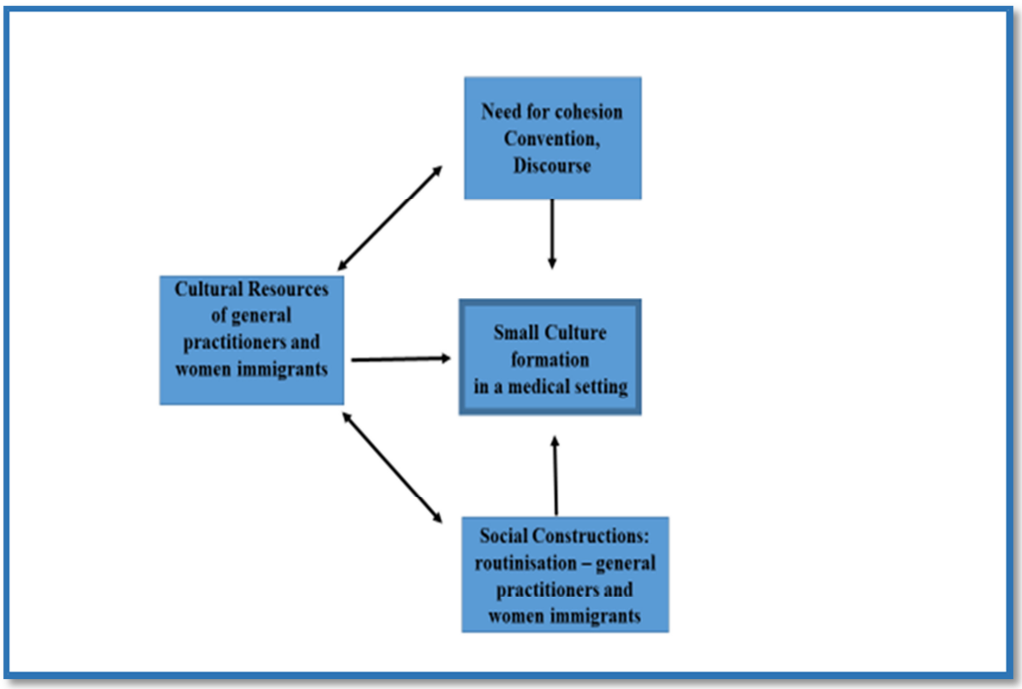

Figure 4: Small Culture Formation in a Medical Setting
Source adapted: Holliday (1999)

Furthermore, routinisation also disturbs the consultation. Both participants bring in their cultural realities and in the case of women immigrants, who are used to a different form of consultation, findit difficult at times to navigate within this medical consultation. In like manner, the general practitioners are challenged when dealing with differences. Nonetheless, both interactants want and concentrate on making the consultation successful via the communication strategies they employ. However, the extent to which that negotiation is successful depends on how far the existing structures are resisted or confirmed by the participants (Holliday, 2011).

Resistance is noticed in view of the system structure, which is said to be "*traditional and conservative,*" where doctors' practices are said to "*have limited opening hours*" according to women immigrants (Isha, personal communication, July 04, 2017 and Marina, personal communication, April 12, 2017) respectively. From the procedural point of view, Prisca feels that "*no general check-ups*" are conducted. Doctors like Sebastian and Susanne are unhappy with the time limitations as less time is devoted to each patient. On the other hand, Jacqueline feels that the women immigrants should adapt to the new setting and accentuates the importance of German knowledge.

On the other hand, Ramona confirms the provision of better standards. Samantha and Letizia admit initial difficulties in the consultation, however, have found it easier to navigate once they have grasped the consultation procedure. Lara, Alia and Ramona accept and have adjusted to the new setting, whereas women immigrants (Dana, personal communication, June 06,2017 and Isha, personal communication, 07 April, 2017) feel that despite their conscious adjustment to the new situation, they do not see much changes in the consultation process as "*things have stayed pretty much the same*."

Thus, it can be said that the ***underlying universal cultural processes*** i.e. the skills and strategies used by all participants to position themselves within the cultural landscape they come from or belong to, do not always achieve the intended goal in the consultation despite concerted efforts. Although group cohesion is attempted at, the influence and extent of influence of all factors illustrated in Figure 3 vary, making the consultation intricate and complex and, in turn, difficult to accurately determine the key influential factors that impact this blur and obscure social interaction.

6.6 EVALUATIVE RIGOUR

In this discussion chapter, I have cited both groups' verbatim statements instead of restating the descriptions.

Creswell (1998) suggested that it was very important to *"bring in the voice of participants"* (p.170) within the text of the narrative. Thus, as regards the data authenticity, I have followed the recommendation to generously use participants' quotations in this discussion section to provide rich descriptions and evidence of participants' experiences (Fossey, Harvey, McDermott & Davidson, 2002).

6.7 SUMMARY OF CHAPTER SIX

Thus, it can be said that 16 themes emerged in total, consisting of seven themes in the group general practitioners and nine themes in the group women immigrants. The themes have been then clustered into common and independent themes. Common themes are those themes and sub-themes that share similar views in both groups. Nonetheless, differences in perspectives have also been observed in these themes and sub-themes. Besides, the independent themes are defined as themes which show no commonalities with the other group.

The common themes such as *communication dimensions* involve the *interaction*, *communication strategies*, *language barriers* and *personal connection* both participants face and perceive. The *consultation context* involves the duality *communication constraints* and *communication differences,* which in turn, cover the *temporal, procedural issues* and *treatment regimen* that take place during the consultation. The *social security system,* also a common theme deals with the issues in the Austrian medical context. *Patients' expectations* and *acculturation* comprise the last two common themes.

The five independent themes that appear among general practitioners entail *patients* – where the sub-themes *illness perception* and *ethnicity* of patients are

discussed in detail; the other remaining sub-, and further sub-themes such as *gender, fear and anxiety* are explained briefly. *Patient compliance,* sub-theme *GP role* are also elaborated upon. Among women immigrants, *emotions, immigrant* and *GP attributes* are described in detail, too. The two independent themes *miscellaneous* and *specialists* have been excluded.

The cultural realities of both groups of participants distinguish the two groups as well as differ within the groups itself. The medical consultation is affected by the conventions, discourse, routinisation, cultural resources, personal trajectories, the underlying universal cultural processes and many more factors. This results in some participants confirmin and some resiting the existing structures, thereby, heightening the complexity of the medical consultation.

Finally, in line with the evaluative rigour of this chapter, I have striven to bring the voice of my participants in detail. I have even included their reactions be it laughter or hesitation in the citation to highlight the authenticity and the in-depth nature of their statements.

7 Chapter Seven Discussion

7.1 INTRODUCTION

This chapter discusses the common and independent themes reported in the previous chapter 6. It critically evaluates the research findings in light of the literature review and highlights the compliance or non-compliance of the findings with previous literature. This chapter also deals with the research findings in terms of cultural elements that appear in this Austrian medical setting.

As this piece of research is based on the social constructionist paradigm, I have striven to explain my opinions, interpretations and the implications of the findings. Finally, I have also conceptualised a theoretical framework on the doctor-patient interaction.

7.2 COMMON THEMES

As mentioned in the preceding chapter 6, five common themes have appeared two common themes entail four and three sub-themes respectively. The common themes are, namely, *social security system*, *communication dimensions* with respective sub-, and further sub-themes like *interaction*, *communication strategies*, *personal connection* and *linguistic barriers*, *consultation context* with related further sub-themes such as *time, procedure* and *treatment regimen, patient expectations* and *acculturation.*

7.2.1 Austrian Social Security System

In general, the participants praise the Austrian Social security system in particular, the subsidised medications, low hospital stay charges and above all the high medical standards but at the same time, they talk of the caveats and pitfalls of the system.

Researchers (Bakic-Miric et al., 2018) state that the goal of any health care system is to deliver the highest quality of care to each patient regardless of race, ethnicity, cultural background and/or language proficiency. There are several studies on difficulties with health service access, service utilisation reported in health literature (Logan, Steel & Hunt, 2016).

Most of these studies, however, have been conducted in North America in view of concordance or discordance between doctors and immigrant patients (Kumar & Diaz, 2019). The bulk of literature on health disparities is focused on America and the disparities reflect unfamiliarity with healthcare processes, difficulty accessing care and poor doctor-patient communication as stated in literature (Kissane, Bultz & Butow, 2010).

Researchers (Nkulu Kalengayi, Hurtig, Ahlm et al., 2012) show that migrants' unfamiliarity with healthcare systems and their inability to navigate through it, are challenges that arise from institutional and societal influences. They add that migrant perceptions about the care and health care are deeply rooted in their past experiences in their home countries, which may be in contrast to the current health care system they make use of.

In view of my research, the Austrian health care system aims at equity and equality of health care, however, the unfamiliarity with the structural aspects of the system, on one hand, and the unfamiliarity with the consultation procedures of general practitioners, on the other hand, as well the poor communication at times account for the disparities faced by my participants - the women immigrants.

Indeed, there are structural difficulties faced by both participant groups that are highlighted in this research. The immigrants, for instance, complain that there are hardly any practices of general practitioners, who come from the minority population or have a different national background. Moreover, they also perceive the system to be traditional and conservative in nature as the insurance companies do not fully cover alternative medicines or forms of treatment.

In addition, they also refer to the difficulties they experience in accessing care during the weekends or late evenings as general practitioners are the first port of call for primary care and since their availability is limited, the women immigrants must seek help from the ER outside the doctors' working hours. This unfamiliarity towards the system makes it difficult for them to navigate well in the system. Both participants complain about the less time they have during visits. One of the main reasons for this is the limited capitation fee general practitioners get for each patient.

Furthermore, evidence from the literature suggests that the continuous growth of foreign-born populations with varied cultural traits and health profiles presents complex challenges for health care delivery due to change in disease profiles, communication problems, diversity of cultures and institutional practices as well as individual past experiences and attributes (Akhavan & Karlsen, 2013; Hultsjö & Hjelm, 2005; Greenfield & Jensen, 2010; Jirwe, Gerrish & Emami, 2010; Priebe, Sandhu, Disas, Gaddini, Greacen et al., 2011; Schouten et al., 2006; Szczepura, University of Warwick & Great Britian Department of Health, 2005).

These challenges are said to influence medical encounters and can result in mistrust that may lead to sub-optimal utilisation of health services, frustrations and errors in diagnosis and treatment regimen (Hultsjö, Hielm, Bertero & Arvidsson, 2011; Hultsjö & Hjelm, 2005; Greenfield & Jensen, 2010; Newbold & Willinsky, 2009; Zanchetta et al., 2006).

In view of my research, it can be said that these assumptions are in line with my piece of study as unfamiliar structural practices mentioned above affect the patients in general and even more those who are unfamiliar with the system. This leads to prolonged, at times sub-optimal utilisation of health services and discontentment among patients – the interviewed women immigrants.

7.2.2 Communication Dimensions

Communication is defined as the interaction between at least two persons who exchange messages and make each other successfully aware of their feelings and ideas by verbal and non-verbal behaviour (van Wieringen et al., 2002).

Several studies (Clever, Jin, Levinson & Meltzer, 2006; Essers, van Dulmen, van Weel, van der Vleuten, Kramer & van Es, 2013; Slatore, Cecere, Reinke, Ganzini et.al., 2010) indicate that effective doctor-patient communication is one of the key ingredients of good medical practice. In addition, they have also established that the quality of doctor-patient communication skills on medical outcomes influences the emotional well-being of both patients and doctors.

It is known that each profession has its language, rules and norms, and its own small culture. When individuals, who are not familiar with this encounter, enter this so-called unfamiliar territory, they are confronted with a different small culture. These individuals are often ill-prepared in managing the new setting in which they find themselves as they are faced with unfamiliar rules and regulations and are not sure how they should behave. Certainly, some immigrants navigate these challenges using their strategies and skills. According to researchers (Butow, Goldstein, Bell, Sze et al., 2011) immigrants often report they struggle with language difficulties; lack information, and professionals do not understand them, which may affect their psychological and physical well-being.

7.2.2.1 Interactions

Interaction shapes the doctor-patient relationship and directs ongoing medical care. Interaction, here, means the conversation between the two where words are used, facts are exchanged and advice is given. This does not exclude the nonverbal expressions and cues embedded in the verbal transaction. These nonverbal expressions give context and enhanced meaning to the words spoken. This intersection of the said

and the unsaid that forges the relationship between the doctor and the patient and the interpersonal dominance, respect, liking or trust is established (Roter & Hall, 2006).

This holds partly true in my research, the general practitioners report that they make the effort of making the interaction between them and the women immigrants successful. They draw or repeat and reconfirm the symptoms described when they are not sure that the message has been understood.

Some use the strategy of asking closed questions to affirm what the patients have explained. Some try to speak slowly and are also sensitised when it comes to providing the patient with information, although they would prefer being direct and straight-to-the-point. Some pay close attention to the non-verbal cues of the patients as regards pain to determine the illness. Finally, if all this does not work to their satisfaction, they call for interpreters.

Despite such endeavours, several women immigrants do not confirm these efforts and methods used by the doctors. They feel that the general practitioners want to get the job done; they are straight-to-the-point and the encounter is fairly rushed, which does not give them much chance to ask questions. Since German is a foreign language, they need more time in explaining and they also lack knowledge of medical terminologies.

Understanding the general practitioners is often a challenge and overwhelming as they tend to use medical jargon; secondly, they speak in German dialect and do not check if the message has been understood nor clarify what the women immigrants explain. Moreover, women immigrants often get the feeling that asking questions is not desired. Thus, misunderstandings occur, which make women immigrants nervous and the medical consultation ends in a frustrating experience.

Drawing on the literature that states the doctor-patient relationship is an intrinsically high context phenomenon within which the interpersonal talk plays an important role in health care (Cline, 2003), it can be inferred that the general practitioners in my research could be more sensitive to the non-verbal cues to decipher

meaning and not mainly concentrate on the explicit verbal exchanges. They are more inclined toward instrumental goals i.e. completing the task in their communicative transaction. The other two objectives identity (managing self-presentation and facilitating the other's identity management) and interpersonal (establishing or maintaining a relationship) (Cline, 2003) appear to get scant attention in my research, as less attention is paid towards the individual and in building a rapport.

7.2.2.2 Communication Strategies

Studies like Jain (2014) report that the kind of strategies used by both participants in medical interactions is often based on the Communication Accommodation Theory (CAT) which is a theoretical perspective for understanding how intergroup differences are managed (Coupland & Giles, 1988). A core tenet of CAT is that people adjust their communication style in intergroup interactions, for example, convergence is a form of adjustment where individuals tries to minimise the differences in communication between themselves and others. These adjustments can be upward or downward convergence.

In my research, both participants have expressed several accommodation strategies that are indicative of downward convergence intending to manage differences in language that occur between the interactants. General practitioners try to look for the right words or metaphors or phrases when the conversation takes place in English. One of them even speaks a bit of Turkish as a considerable number of his patients originate from Turkey.

Simultaneously, the women immigrants request their general practitioners to speak slowly or use a mix of German and English sometimes even Latin words to explain the illness. They try to keep conversation simple and make use of gestures; they also clarify medical jargon. Some of them are proactive and inform the doctor about their allergies, or implications of medications taken in their previous visits when the doctor does not address them.

However, it can be said that although convergence is attempted to some extent, it is not always successful. Non-accommodative practices also occur where "*speech maintenance*" is observed (Giles, 2008). Many general practitioners still tend to use medical terminologies or speak in their regional dialect making it more difficult for the women immigrants to understand them. Also, the communication is perceived as quick and straightforward by women immigrants as open-ended or follow-up questions are not encouraged. In such cases, the women immigrants clamp up and do not speak much; just get the basic stuff done; they take their partners along to the consultation or get the check-ups done in their home country.

7.2.2.3 Communication Barriers – Language

Since languages are a way of facilitating thoughts within individuals own large and small cultures, they also prevent individuals from grasping possibilities inherent and encoded in other systems resulting in communication barriers. In the medical context, language barriers make it difficult for doctors to ask questions about the patient's medical history in such a manner that is comprehensible to the patient (Jain, 2014).

Much research indicates that linguistic barriers may affect the health care process (Jain, 2014). Research goes into detail in listing that language difficulties may lead to misdiagnosis or delayed diagnosis, inappropriate treatments, poor adherence to recommended treatments (Iacono & Johnson, 2004; Rivadeneyra, Elderkin, Silver & Waitzkin, 2000).

These views are consistent with my research. The general practitioners firmly believe that language problems are the biggest obstacle; sometimes, it is in the very last moment that they detect what the patient's problem is. One doctor expressed that he only realised in the follow-up consultation, that the patient had misunderstood the treatment regimen. Moreover, women immigrants also affirm that misunderstandings take place, which make them feel uneasy. They have difficulties not only in speaking German but in understanding the dialect.

In research (Harmsen, Nermsem, Bruijnzeels & Meeuwesen, 2008) conducted, they confirm that the patients' cultural views, language proficiency are more important than ethnic origin per se. The study indicates that concerning communication there is general satisfaction, however, in issues such as an explanation of medication or diagnosis or decision about treatment there is room for improvement. Schouten et al. (2006) also add that the linguistic barriers and divergent beliefs often make it difficult for the doctors to deliver good quality care to a diverse group of patients, where each brings his/her unique background to the medical encounter.

These views also hold true in my research. For one, both groups confirm that language barriers hinder communication. In addition to language, the patients' cultural views and beliefs are vital aspects that must be taken into account. As explained in chapter 6, section 6.5, each interactant brings his/her unique background to the medical encounter. The individual's background is moulded by various factors personal trajectory, cultural resources etc., and not just by his/her ethnic origin. Ethinicity plays a role but it is not the main component to be considered. Moreover, the individual may not "*represent*" the specific ethnicity, s/he may be categorised into. As seen in section 6.5 due to the complexity of factors that influence us individuals, it is very difficult to accurately point out, which key components impact the interactants, which come into fore in the consultation.

Researchers (Wiking, Saleh-Stattin, Johansson & Sundquist, 2009) found that doctors reported communication difficulties affected their ability to understand symptoms and treat diseases and to empower patients regarding their health care. Minority patients who do not speak the same language as the doctor are less likely to receive empathic responses from physicians; may not be able to establish rapport with physicians; nor receive sufficient information; and may not be encouraged to participate in medical decision making.

This assumption may be partly true in my study. The doctors discern that it is important to listen attentively to their patients and some are sensitive in the way they

formulate their questions, in contrast, almost all women immigrants complain that their general practitioners do not try to establish a rapport.

Now, whether this "*no personal connection*" is due to linguistic barriers or other factors such as the doctor's personality or time or procedural constraints cannot be confirmed. A few women immigrants, in fact, desire that they are encouraged in decision making as they are accustomed to this from their home countries. Hence, it cannot be deduced in my research if linguistic barriers are the main reasons for less or no rapport.

As mentioned in the previous section both participants try out various strategies to make interaction beneficial. Although for general practitioners, language is the biggest obstacle in a consultation, they try to be accommodating and speak in English, as well as use other communication strategies as mentioned in the previous section. When all those strategies including sign language do not work, then they insist on interpreters.

Although convergence is given to a great extent, many doctors show "*speech maintenance*" where they speak in German dialect to their patients and or use medical jargon. These are indicative of the maintenance of their respective social identity, where interactants feel they are representing different groups or communities, large and small cultures with which they share a strong affiliation and where this style of communication is a fundamental dimension of their social identity (Giles, 2008).

Some studies (Karliner, Jacobs, Chen & Mutha, 2007) claim that since language barriers can pose a threat to the quality of care, professional interpreters are considered to be the best bridge for language barriers. This is echoed too in my study as in the best interest of the interactants, many general practitioners insist on an interpreter be it a family member, who has a command of the German language or a professional interpreter when they realise that communication is tough. Likewise, the women immigrants bring along their partners or friends when they perceive that the medical visit may be linguistically challenging.

Various studies have found that physicians' who speak the patient's language show improvement in several processes such as asking more questions, better health outcomes, recall more information than patients whose physicians do not speak their language (Pérez-STable, Nápoles-Springer & Miramontes, 1997; Seijo, Gomez & Freidenberg, 1991).

This has also been confirmed in my study as several women immigrants expressed that when their doctors spoke English well, the interaction was smooth. Conversely, they also felt that when their German language skills improved over the years, the communication with their doctors had considerably improved. One of the women immigrants also mentioned that her general practitioner encouraged and supported her when she realised that she was attempting to speak in German.

7.2.2.4 Personal Connection

Several studies (Street, 2001; Watson & Gallois, 2007) define interactions between patients and doctors as mainly intergroup encounters.

The role of the patient or the doctor is salient and drives the interaction. When both tend to keep their roles, the consultation is said to be high in intergroup salience and low in interpersonal salience and the communication will mainly concern the patient's condition and treatment regimen.

Watson and Gallois (1998) found that although patients found such encounters acceptable, they are not rated as positively as interactions that are more interpersonal where the doctor shares some personal information or is interested in knowing more about the patient.

Further studies (Harmsen et al., 2003; LaVeist & Carroll, 2002; Murray-Garcia et al., 2000) show that the lack of socio-emotional expressiveness makes it more difficult to establish a relationship of mutual trust with shared medical decision-making and mutual understanding, which is essential as these deficits result in diminished patient compliance and satisfaction.

A Dutch study (Schouten et al., 2009) determined that intercultural consultations could be distinguished from intracultural consultations by the use of retractive behaviour of doctors such as ignoring comments and driving through the medical agenda.

This Dutch study confirms that doctors' main focus is on medical problems, which overshadow other aspects of the consultations, most notably the existential dimensions i.e. the personal aspects of patients' conditions. Personal meanings of the patients' conditions have been overlooked (Ageldahl, Gulbrandsen, Forde & Wifstad, 2011; Levinson, Gorawara-Bhat, Dueck, Egener, Kao & Kerr, 1999).

Others have described that doctors lack empathetic responses. It is only in the last few decades that this relationship between patients and doctors which always existed has been elevated to a more central status where it is considered key to proper treatment. The patient is seen as a primary figure in the process and outcome of treatment and the relationship between the two as vital for effective care (Bennett, Fuertes, Keitel & Phillips, 2016).

These aspects hold as regards my research. Based on the findings reported in chapter 6, most of the women immigrants have been fairly satisfied with the interactions but almost all desire that their general practitioners should give them more attention by asking about their past illnesses; by involving them more in the decision making; by letting them ask more questions and by showing a more personalised approach towards them. They get the feeling that their doctors are less keen on knowing them and that there is not much personal connection between them. Moreover, a bit of small talk at the beginning of a consultation would also put them at ease.

The general practitioners, on the other hand, do state at times that they provide equal treatment and listen attentively to their patients. They also mention, on a side note, that it is important to empathise with the patients and to build trust by treating them as equals and in a friendly manner; however, not much emphasis has been laid on this aspect in the interviews.

According to Aitini et al. (2014) communication has a content and a relationship aspect. The content is WHAT is verbally said and the relationship aspect is HOW it is said nonverbally. Both the sender and the receiver of information interpret their behaviour during communication merely as a reaction to the other's behaviour. These concepts are very important, as, in addition to identifying the patient's illness, the doctor should also focus on the social, ethical and spiritual aspects and on what can only be defined as "*the biography*" of the patient (Aitini et al., 2014).

Apart from the small talk aspect and attentive listening which play a vital role in the interaction, non-verbal cues also impact the medical transaction as face-to-face interaction is made up of verbal and non-verbal communication. According to Jain (2014) nonverbal communication plays an important role in emotional expressiveness and the maintenance of relationship-centered patient care.

In my research, some women immigrants feel that the non-verbal cues of the general practitioners such as no eye contact or no friendly greeting; or being glued to their computers while the women immigrants talk to them; all these gestures make them feel uneasy. In contrast, one women immigrant (Linda) feels that not taking the emotional aspect into account is a sign of a doctor's professionalism as doctors deal with personal situations and it is difficult for doctors to gauge to what extent they can express their sensitivity. The general practitioners, on the other hand, pay attention mainly to non-verbal cues such as patients' facial expressions when it comes to identifying the pain.

In addition, existing literature (Knapp & Hall, 2010) also strongly suggests that non-verbal behaviour is influenced by large culture as cultures encourage overall expressivity or discourage it. Since non-verbal behaviour is closely connected with verbal messages, intercultural communication can be marred by ambiguity and uncertainty due to the cultural differences in the non-verbal behaviours associated with the verbal messages. Therefore, it is quite likely that the non-verbal cues are misunderstood because the cultural filter one uses to interpret the non-verbal behaviours of others may or may not be the cultural framework within which the person's behaviour is rooted.

This assumption is in line with my research as the reactions of the women immigrants vary when it comes to their perception and reactions towards the non-verbal behaviours of their doctors. Some feel unwelcomed; one considers it as a sign of professionalism; some accept the overall consultation as it is and are fairly satisfied with the personal connection they share.

Additionally, there are several studies conducted on gender communication where literature states that gender has a predisposing influence on communication, as it is said that men and women differ in their styles of communication (Street, 2002; Tannen, 1990). For example, women generally talk and tend to build rapport, whereas men use talk as a means of establishing status and independence. Women's language is perceived to be of aesthetic quality (pleasing) but less dynamism (strong and active) than men's discourse. In the nonverbal domain, women are said to be more expressive and accurate at perceiving emotions of others than the men (Street, 2002; Tannen, 1990).

It cannot be discounted that gender may be a factor that influences the communication and that the women immigrants desire more relational communication based on the aforementioned research. However, I contend that although most women immigrants in my research aspire to have more relational communication, I think that it may be one of the factors that impacts behaviour, beliefs and perceptions and, in turn, the communication. So, I have not focused on this aspect in isolation to other personal and situational attributes that influence the doctor-patient interaction.

7.2.3 Consultation Context

Two diverse perspectives have been found in the findings, namely constraints and differences. The general practitioners consider the challenges they face during the consultation as constraints, whereas the women immigrants speak of the differences in the consultations they experience as opposed to their home country. The consultation context has been like in the findings divided into three parts: time, consultation procedure and treatment regimen.

7.2.3.1 Time

Studies in Sweden show that the consultation rate is higher among ethnic minorities than with Swedish born persons (Wiking et al., 2009). This is mainly due to the fact that linguistic barriers prevail. This opinion resonates too in my research among the general practitioners, who feel that it is a challenge when they cannot explain to or understand their patients owing to the language problems. Quite often, it is in the very last moment of the consultation that they identify the medical issue.

However, scholars (Tocher & Larson, 1998; Wiking et al., 2009) have found in their research conducted in Sweden that physicians generally do not spend more time providing care to non-English or non-Swedish speaking patients although they feel that they do so because of the language and cultural barriers. This point of view is found among the women immigrants in my research, who feel that limited time is a common phenomenon with doctors in their home country, too, however, they believe that despite this limitation they seem to cover more with their doctors in their home country than in Austria. Here, they get the feeling that not many questions are asked and they have less opportunity to give and to elicit more information.

Research also, on the one hand, confirms that time constraints certainly do not let doctors sufficiently deal with psychosocial aspects, on the other hand, literature states that attention to psychosocial aspects does not have to be time-intensive (Butalid, Verhaak, Tromp & Bensing, 2011). As mentioned earlier in this section and in section 7.2.2.4, the women immigrants feel the communication is more restricted and most desire more relational communication

7.2.3.2 Consultation Procedure

The consultation procedure is fairly standardised where the patient after having first completed the organisational matters with the assistants, meets up next with the doctor. The general practitioner asks about the symptoms, confirms the diagnosis and then prescribes the treatment. In general, it is the same procedure for all irrespective of

the patients' ethnic background. This kind of conduct which is regularly seen in medical encounters is defined as "*medical processing*" (Macnaughton, 2009).

The biomedical clinical training, as well as knowledge based on a scientific medical paradigm, has an impact on general practitioners' health beliefs, where the focus is mainly on evidence-based medicine (Penn, Kar, Kramer, Skinner & Zambrana, 1995), and this, in turn, has its implications on doctor-patient interactions as the communication between the two becomes more task-oriented as also indicated in several studies (Butalid et al., 2011). The task-oriented communication is defined in various terms such as instrumental communication or "*cure-oriented interactions*" (Bensing, 1991), which often includes the doctor asking about the symptoms, recording information in the patient's medical chart, explaining tests or illnesses and prescribing and explaining medications.

This phenomenon holds in my research as the women immigrants strongly voice that the general practitioners solely focus on the medical issue like Dana says, she is left with the feeling - "*get in, find a solution and get out*" (Dana, personal communication, June 06, 2017). Linda feels that she is on "*an assembly line*" (Linda, personal communication, February 02, 2018) and wishes that the doctors would invest time in getting to know them and would appreciate "*care-oriented interactions*" (Bensing, 1991) or socioemotional communication within the scope of their therapeutic relationship as also proved in several studies where patients feel that their doctors are not really interested in them (Aitini, 2014; Fallowfield, 2004;).

Socioemotional communication or biopsychosocial approach aims at making patients feel comforTable, relieving patient anxiety and building a trusting relationship (Roberts & Aruguete, 2000). This should, in general, involve positive talk where the physician expresses friendliness, empathy, sympathy, concern, reassurance and partnership building. The specific elements of socioeconomic communication may include greeting the patient in a friendly way; addressing the patient by name; engaging in small talk; being friendly and listening attentively (Desjarlais-deKlerk & Wallace, 2013).

There are varied views as regards socioemotional communication in my research. Some women immigrants feel that their doctors are friendly, but are very task-oriented. They concentrate mainly on identifying the illness without gathering much information about the patient per se or her medical history. There is no small talk or attentive listening nor any signs of partnership building, whereas some feel are content with their doctors as they perceive that their doctors are encouraging, supportive and ask further questions.

Many studies show that patient-centeredness is said to be the best communication style for doctors – one that involves high levels of caring and sharing (Cousin, 2011). A caring communication style is set out to create and maintain a good relationship with the patient with the desire to convey warmth, friendliness, interest, empathy and a desire to help (Cousin, 2011). Sharing also called low dominance is characterised by nondirective communication where both participants set a joint agenda, no orders given, no medical jargon used and open-ended questions are asked. Patient-centeredness is not given in my research where a joint agenda is set, no medical jargon is used and open-ended questions are asked. Most of the general practitioners affirm that they generally pose specific or closed questions to understand the patients' problems.

7.2.3.3 Treatment Regimen

The study performed by (Nkulu Kalengayi et al., 2012) explain that migrants are often unfamiliar with the health care system or have little knowledge of how it works. According to the above study, they are often described as impatient, demanding and sometimes aggressive, in need of immediate care or prescriptions even when it is not required.

This phenomenon is expressed by the general practitioners in my study too. This group of participants feels that their patients, women immigrants in general, often desire immediate effect and sometimes the prescribed treatment is not up to their expectations. They often insist on further screenings or referrals or antibiotics even when these are not required.

Conversely, some of my interviewed women immigrants express positively that their doctors are accommodating as they prescribe alternative medicines when asked for. They also strongly appreciate the fact that the doctors do not show any money-making intentions as they are not affiliated with pharmaceutical companies nor do they insist on additional screenings.

7.2.4 Patients' Expectations

Researchers (Röder & Muhlau, 2012) state that expectations are not only shaped by the realities of the host country but also by the experiences in the home country. In the case of immigrants, the dual frame of reference (Suárez-Orozco, 1989) has been identified as an underlying mechanism where immigrants evaluate the present situation in the host country with past experiences from their home country. According to this dual frame of reference, immigrants tend to compare the realities of the host country with their experiences in the home country as a reference point.

Scholars (Wiking et al., 2009) found that when patients are understood, given explanations and emotional support, their expectations are met. Effective communication and delivery of information are important factors for patients' satisfaction (Wiking et al, 2009). This aspect is not fully in line with my research based on the diverse responses. Some women immigrants feel that the doctor understands their problems, whereas some feel that the doctor is not interested in knowing much about their issues; however, most of them get the feeling that the doctors do not listen to them actively nor do they give them any kind of assurance.

A good doctor-patient relationship is of importance as stated by scholars (van Wieringen et al., 2002). According to these researchers, doctors' comprehensive knowledge of his/her patients and the patients' trust in their physicians are the variables that are strongly connected to adherence to the doctor's advice. The patients' trust is also strongly associated with patients' satisfaction with their general practitioner. Satisfaction is an affective reaction to communication that meets or fails to meet one's expectations (Spitzberg & Hecht, 1984). Furthermore, patients' dissatisfaction and

complaints are mainly due to breakdown in the doctor-patient relationship (Gasparik et al., 2014; Verlinde & De Laender, 2012).

This is partly true in my studies as the women immigrants would appreciate a better doctor-patient relationship where their questions are answered; basic check-ups are carried out; more patience, interest and understanding is shown; there is no stereotyping; made to feel at ease so that they open up and talk more freely about their health. These contributions of the women immigrants can also be connected to the dual frame of reference as they may be used to dissimilar practices in their home country.

In those cases, where breakdowns inevitably occur, the women immigrants change their general practitioners or seek advice from their doctors in their home country. The latter action also deduces that when the circumstances in the host country are not favourable compared to the situation in the home country, then the dual frame of reference will induce a more negative evaluation of the situation in the host country.

Furthermore, in view of literature on gender in health care communication, it can be said that consistency is given with the aspect of female patients wanting more empathic listening and longer visits. The expectation for this communication style, however, relates to both same gender and different gender interactants. In general, the women immigrants would appreciate a more caring communication style from both male and female doctors. Thus, this aspect does not accord with the literature that claims that a more caring communication style is expected from only female doctors.

However, it must be said that research (Zebiene, Svab, Sapoka, Kairys, Dotsenko, Radic & Miholic, 2008) indicates that the highest satisfaction rate was not always found with the high sharing communication. A lot depends on the attitude of the patients towards sharing, as patients have been most satisfied with a high level of sharing or with a low level of sharing. Some patients prefer a physician's communication style with high levels of sharing and while others prefer a more directive communication style.

This phenomenon also resonates in my studies as overall out of the thirteen women immigrants interviewed, eight seem to be satisfied with their general practitioner's communication style and procedures, whereas five demonstrate discontent with the way of interaction; procedures like opening hours; the absence of a female assistant during check-ups, etc.

This section highlights predominantly the expectations and the corresponding reactions of the women immigrants. This is because the doctors interviewed did not say much about patients' expectations, nor did they express what they expect from patients. Based on the data, it can be said that they believe in following the same procedure for all patients; they also feel that immigrants expect immediate cure when they visit them; for Sebastian it's like having "*a magic wand*" (Sebastian, personal communication, February 08, 2018).

7.2.5 Acculturation

Acculturation is described as the process of adaptation of individuals to a new environment by adopting beliefs, customs or values of the host country (Mantwill & Schulz, 2017). The length of time living in a new country, as well as language proficiency and usage, are the most commonly used determinants of acculturation (Abraido-Lanza, Echeverria & Florez, 2006). It is assumed that higher acculturation leads to higher health literacy levels. Linguistic acculturation allows immigrants to increased access to health information and health care services.

This assumption is partly in line with my research. The women immigrants interviewed have not been living in Austria for longer than 10 years. Almost all agree that better command of German has improved their interaction with their general practitioners as they could express the symptoms better as well as understand them linguistically better.

It cannot be said that higher acculturation has led to higher literacy levels as all women immigrants generally care and are concerned about their health and are proactive about it in their ways. For instance, they would give their doctor information on allergies or past medical history even if not asked for; they would go for a second

opinion or seek medical advice from their home country when uncertain. Thus, I cannot infer based on my findings that the high literacy level of my sample group is due to higher acculturation.

Scholars (Navas et al., 2007) explain that there are four types of attitudes towards acculturation, namely: integration, assimilation, separation and marginalisation. Taft (1966) delineated seven stages of "*assimilation of individual immigrants,"* moving progressively from the "*cultural learning*" stage to the "*congruence stage*" (Jackson, 2012).

This is partly reflected in my research as some women immigrants accept the differences such as their struggles with communication and structural issues. Nonetheless, they see dealing with these issues as a way of integrating into the new environment. Some doctors too, try their best to accommodate the interests and requirements of their patients as mentioned earlier, whereas some strongly feel that the patients should adjust to the host country like even doctors would have to do if they lived elsewhere to function well.

Kim (1988, 2001, 2005) came up with the integrative communication theory of cross-cultural adaptation that is defined as the phenomenon where individuals upon relocating in an unfamiliar environment strive to establish and maintain a relatively stable, reciprocal and functional relationship with the environment. According to the scholar, when individuals enter new and unfamiliar cultural practices, they undergo to some extent new cultural learning i.e. the acquisition of native cultural patterns and practices in areas of direct relevance to the daily functioning of the individual.

This is a change in individuals whose primary learning has been in one culture and who take over traits from another culture. As new learning takes place deculturation or unlearning of some old cultural habits tend to occur in the sense that new responses are adopted in situations that would have evoked old, habitual ones. Thus, an interplay of acculturation and deculturation occurs and it is the internal transformation that an individual undergoes in the direction of assimilation. Individuals vary by choice or by circumstances in their adaptation process.

In the case of the women immigrants the adaptation process varies as some find it difficult to-date to accept the changes and often keep themselves aware of the fact that they are not from here; for some there seems to be no change in their experiences over the years as they feel "*things have pretty much stayed the same*" (Dana, personal communication, June 06, 2017)

Certainly, the readiness to undertake the process of intercultural adaptation also depends on factors such as personality and characteristics etc. However, based on my findings, I get the impression that although efforts of mutual adaptation are made to some extent by both groups, a greater degree of it would be appreciated by both groups.

7.3 INDEPENDENT THEMES – GENERAL PRACTITIONERS

As illustrated in Figure 18, the independent themes that emerged from the group general practitioners are *patients* with sub-themes *illness perception* and *ethnicity, patient compliance*, and the sub-theme *GP role*, which have been dominant and hence, are discussed in detail. The other sub-themes *fear & anxiety, gender* and *patients' personality*, and the theme *patients' education* are not discussed as they were marginally addressed. The independent theme *miscellaneous* will not be referred to. Nonetheless, these sub-themes although not dealt with in my study, are certainly worth further research in prospective studies in Austria.

7.3.1 Patients

About 50% of foreigners constitute the patient population, which denotes that almost half of the patients come from another ethnic background and are distinguished by the doctors based on their national identity. Furthermore, some doctors acknowledge that the patients' perception of health and body functions is culturally influenced.

7.3.1.1 Illness Perception

The health belief systems can be divided into three major categories: supernatural, holistic and scientific. The scientific belief system focuses on objective diagnosis, scientific explanations and approaches to illness. It also relies on procedures such as laboratory tests to verify the presence and diagnosis of disease. This belief called the Western biomedical also forms the basis of medical diagnosis and care of the Austrian health care system, medical education and practice.

Beliefs about illness and treatment and health, in general, vary from person to person as they originate from the way the person perceives the world and the large culture also influences them, as it creates patterns of beliefs and perception of health and illness. These patterns, in turn, influence how health is perceived; to what it is attributed and how it is interpreted; as well as how and when health services are sought (Bakic-Miric et al., 2018).

This echoes to a large extent in my research. The women immigrants have different perceptions of seeking health services and the kind of service they are accustomed to; as well as the consultation procedure and treatment prescribed. For instance, some desire only antibiotics, some prefer alternative forms of medicine and some are glad that not much is prescribed as compared to the practices in their home country.

The doctors, on the other hand, acknowledge that illness perception is culturally shaped and try to accommodate the interests and needs of their patients so long as they do not interfere with the scientific treatment plans such as medications, surgeries (Bakic-Miric et al., 2018). This holds in my study too, for instance, they at times even prescribe medications desired by the patient although not required at that stage of illness.

According to scholars (van Wieringen et al., 2002), it is not only a language problem but also a cultural difference expressed in a way people think about health disease and health care. This is also reflected in my study, as the doctors understand how people express themselves in view of health disease and health care is culturally

different. They observe that the way pain is expressed and the fear sensed by patients from another ethnic background is much stronger.

Thus, as many scholars (Wiking et al., 2009) state that it is important for doctors to understand the meaning of behaviours and ideas – including patients' conceptions of health and illness – within their cultural context. This is true to a great extent as the general practitioners try to the best of their ability to understand their patients, one of them has learned a bit of Turkish to be able to converse and understand his patients better; others try to accommodate the interests and needs of their patients as much as possible.

7.3.1.2 Ethnicity

In my research, the doctors very strongly refer to the national identity of their patients. They tend to stereotype when they face differences. Stereotypes are overgeneralisations of group characteristics or behaviour that are applied to individuals of those groups (Allport, Clark & Pettigrew, 1979). Stereotypes are simplistic impressions of the person stereotyped and can be negatively bias impressions (Delia, 1979), placing others in rigid and negative categories. They may lead to prejudice attitudes towards groups (Devine & Elliot, 1995) make unfair attributions and act toward groups in particular ways (Foley & Kranz, 1981; Manusov, Manning & Winchatz, 1997).

This as mentioned earlier is true too in my research. The doctors assume that the Syrians have had a better medical infrastructure in their home country as they are well-groomed; have undergone several check-ups; and have a high vaccination status; thus they claim that Syrians tend to hold different expectations as compared to Afghans and Africans; sometimes the general practitioners feel they should represent a Shaman in order to get rid of the wall of fear they sensed when dealing with some cultural groups.

Stereotyping impedes effective communication but still, a natural part of the communication process as categorisation is done or even needed to make a sense of the world (Hughes & Baldwin, 2010).

This is partly true I would say in my study. Stereotyping is carried out by the doctors as a form of categorisation to understand and give meaning to the reality but whether stereotyping is the main reason for impeding effective communication cannot be deduced. Certainly, the doctors are attuned to differences but it seems to me that they partly assume the uniformity of belief and practice regarding illness within a particular ethnic group and this form of stereotyping would create more barriers. Thus, it can be said that stereotyping of patients may play a role in creating barriers or ineffective communication but is certainly not the main cause of less effective or ineffective communication in my research

7.3.2 Patients' Compliance

Patient's compliance to the treatment regimen is said to be high when there are compulsory follow-up consultations. Such follow-up consultations are usually agreed upon when the patient is severely ill or when they collect unemployment benefits.

Studies have shown that caring leads to more adherence to treatment, greater satisfaction of the patient; and better psychological adjustment to the illness (Cousin et al., 2011).

For scholars (van Wieringen et al., 2002), when compliance prevails then there is mutual agreement in the consultation. However, there are several factors associated with non-compliance such as beliefs and expectations of patients on disease and prescribed treatment and poor communication between the interactants. Furthermore, patients who perceive that their doctors know them as people, rather than just as patients (Beach, Keruly & Moore, 2006), adhere to treatment recommendations more consistently and experience more positive health outcomes. Adherence is also improved when doctors demonstrate more warmth, openness and interest (Fox, Heritage,

Stockdale, Asch, Duan & Reise, 2009) engage in more shared decision making with patients (Shah, Hirsch, Zacker, Wood, Schoenthaler, Ogedegbe & Stewart, 2009) and demonstrate less discord with and control over patients (Lakatos, 2009).

According to the general practitioners, 10% of the patients show non-compliant behaviour. They state that one-third show concordance as they take the prescribed medicines; one-third do not even collect the medicines from the pharmacist and the rest may collect them but do not take them.

Satisfaction is closely related to more fundamental outcomes such as adherence to treatment suggestions and health outcomes. As expressed in section 2.3.1.4, according to scholars (Cameron et al., 2000) satisfaction is higher when patients get the opportunity to ask questions, when they feel understood. Moreover, levels of satisfaction with doctors and doctors' communication are positively related to adherence; more satisfaction and improved communication lead to more adherence. Thus, it can be said that satisfaction directly impacts health outcomes and quality of life.

Hence, in my study, doctors concede that when the patients are satisfied with the consultation then the adherence rate is higher. They are cognizant of the importance of effective communication. Nonetheless, they accept the fact that the adherence rate in only about 10% and feel it is the patient's responsibility to follow the prescribed treatment. Overall, out of the thirteen women immigrants interviewed, eight seem to be satisfied with their doctor's communication style and procedures, whereas five demonstrate discontent with their way of interaction and procedures.

7.3.3 GP Role

There are various roles a general practitioner may have in the consultation process. As explained in section 2.3.1.3, according to Emanuel and Emanuel (1992), there are four kinds of roles: paternalistic, informative, interpretive and deliberative. Each of these types explains the role of the doctor in a medical consultation. The

paternalistic and the informative can be seen on one end of the continuum, where the focus is mainly on biomedical aspects.

The interpretive and deliberative type can be placed on the other end of the continuum, where the interpretive doctor is like a counselor who gives information to the patient but does not make the decisions for the patient. In the last type, the doctor by respecting the patient's values and beliefs helps the patient through their conversation to understand what s/he can do. The doctor may offer suggestions; however, it is the patient, who decides what is best for him/her. The doctor is more like a friend and not the expert or the decision-maker.

Roter (2000) demonstrates three main types of doctor-patient relationship where each highlight a way of communication, decision making and use of power. The three types are namely: paternalistic, consumerist and relationship-centered.

Over the years the doctor-patient relationship has changed in line with the principle of autonomy, where patients are left to decide on matters related to their health. There are various models of interaction – from the paternalistic model, where the doctor makes the decisions and sets the layout of the interaction followed by the patient; to the informed model, where the doctor does what he can to include the patient's preferences in decision making. The shared decision model aims at the patient's participation and getting involved in clinical decision making (Katz, Broder-Oldach, Fisher, King, Eubanks, Fleming & Paskett, 2012).

It is known that the information provided by the doctor is central to patient involvement in decisions that affect them; helping them to cope better with their illness (Schoen, Osborn, Huynh, Doty, Zapert, Peugh & Davis, 2005). In view of my research, the doctor's role also varies from a paternalistic to an informed model during their consultations. The general practitioners are at times hierarchical in nature; at times service and information providers; sometimes they serve as managers. In general, they

tend to share a symmetrical relationship with their patients as also confirmed by some women immigrants.

Several empirical studies have shown that doctors rarely involve patients in the clinical decisions made (Karnieli-Miller, Werner, Neufeld, Kroszynski & Eidelman, 2009; Rogg, Aasland, Graugaard & Loge, 2010). Other research has highlighted how doctors focus on the technical and biomedical aspects of a case and play down patients' values and feelings (Corke, Stow, Green, Agar & Henry, 2005). Studies confirm that the doctors' main focus is on medical problems, which overshadow other aspects of the consultations, most notably the existential dimensions i.e. the personal aspects of the patients' conditions (Levinson et al., 1999; Agledahl, et al, 2011).

Understanding the personal meanings of the patients' conditions have been overlooked. Others have described that doctors lack empathetic responses. The regularity of this conduct, as mentioned earlier in section 7.2.3.2 is defined as "*medical processing*" (Macnaughton, 2009). More attention to the suffering of the patient; requested personal involvement of the doctor, and the emphasised need to address patients as whole human beings with unique lifeworld have been called for (Barry et al., 2001; Langewitz, 2007).

These findings also resonate in my research as from some women immigrants' perspective, doctors mainly focus on the biomedical problem and are not interested in establishing a rapport, which would make them feel more at ease and open up during a consultation.

Patients and many doctors have welcomed the development of a more humanistic approach as a reaction to impersonal and scientific modern medicine (Bradford, 2005; Halperin, 2010). In practice patients want doctors to listen to them; to resolve their doubts; to explain what is happening to them (Guadagnoli & Ward, 1998). Patients are willing to discern the choices they have although it is doubted if they want to have the final word (Ford, Schofield & Hope, 2006; Jansen, van Weert, van der Meulen, van Dulmen, Heeren & Bensing, 2008).

Some patients report that they are satisfied with the information provided to them; others claim that they do not have all the information they would like to have, or they have doubts; or concerns as they have intrinsic difficulties in asking (Ashbury, Iverson & Kralj, 2001; Coulter, 2002). This also holds in my research as although doctors' role is defined as symmetrical by some women immigrants, they still desire more information; they wish attentive listening and treatment choices; simultaneously some have difficulties in voicing their doubts and concerns.

7.4 INDEPENDENT THEMES – WOMEN IMMIGRANTS

Referring to Figure 18, the independent themes that emerged from the group women immigrants are *emotions, immigrant attributes* and *GP attributes*, which were dominant and hence, are discussed in detail. The other independent theme *specialists,* as explained in section 6.4, is not directly related to this study, so this theme will not be focused on.

7.4.1 Emotions

Some literature states that patients whose ethnic origin is different from that of the doctor evaluate health care as less positive compared to the patients with the same background (Harmsen et al., 2006). On the other hand, recognising and responding emphatically to patients' emotions has a positive effect on patient satisfaction and outcomes (Kale, Skjeldestad & Finset, 2013). Expressing negative emotions may reflect distress and concerns of patients as regards the explanatory model of their illness. These emotions or cues may contain information relevant to diagnosis and treatment.

The outcomes in view of emotions resulting in my study have been positive or uncertain among most of the women immigrants; a few have expressed themselves to be anxious or negative in their outlook towards their medical encounters. Many of the women immigrants feel that they can speak freely and openly with their general

practitioners. They can express their concerns and the doctors show willingness in providing more information. They feel very safe and secure and trust their general practitioners.

Uncertainty, which is the second strongest emotion in my study, can be defined as the inability to predict and explain others' behavior, beliefs, attitudes or values (Berger & Calabrese, 1975). Uncertainty is said to decrease as individuals get to know each other better. This is true in my study since some women immigrants feel uncertain as they are of the impression that their expectations are not met, since the level of health care they expect, is not delivered.

Their uncertainty is mainly based on lack of time and rapport; straight-to-the-point attitude; basic check-ups not being carried out prior to diagnosis; the feeling of not being welcomed, all issues of concern. However, from the group of women immigrants, only one who voiced her uncertainty, feels that it has slightly decreased as her relationship with her general practitioner improved.

Anxiety Uncertainty Management (AUM) theory (Logan et al, 2016; Gudykunst, 1998, 2005) suggests that anxiety and uncertainty are underlying factors that influence the effectiveness of cross-cultural interactions. To facilitate effective communication, both should be at an optimal level because the higher the level of anxiety or uncertainty, the lower is the willingness to communicate.

This is also highlighted in my study where women immigrants feel anxious as they are not given much time to answer the questions nor being asked basic check-up questions; some get the feeling of not been taken seriously; no personal connection, and unprofessional responses from their doctors at times leading to frustration and resulting in less communication.

Although some women immigrants expressed dissatisfaction, they feel that the chances of getting misdiagnosed are low; however, most of them agreed that their general practitioners are very respectful. Nonetheless, they would appreciate if they showed more cultural sensitivity.

7.4.2 Immigrant Attributes

An observational study on patient visits to general practitioners found out that asking about patient's needs, perspectives and expectations; attending to psychosocial context; encouraging patients' involvement in decisions predicted lower diagnostic testing expenditures, lower total hospital and ambulatory care expenditures (Epstein, Fiscella, Volpe, Diaz & Omar, 2007).

The above-mentioned researchers articulated four patient-centered communication domains that include the patients' perspectives, acknowledging the psychosocial context and encouraging both shared understanding and shared responsibility. They also described interrelationship among patients' factors (personality, values and emotions), relationship factors (concordance of race and expectations; relationship duration and trust; expectations), health system factors (access to care, environment, visit length) and clinician factors (personality, risk aversion, visit frequency).

This holds partly true in my research, to the extent that many women immigrants are accustomed to a different form of communication such as more open questions and follow-up questions; more information exchanged and issues covered in the same amount of time back home; in establishing a personal connection and being involved in decision making, which they also expect from the Austrian general practitioners but not fulfilled yet. They are used to asking more questions; having a better rapport etc. thus, find it difficult when their expectations are not met.

Studies have also shown that it is difficult to meet the people's needs when their values and background are increasingly diverse and not well understood (Whittal & Rosenberg, 2015; Marks & Worboys, 2002). This is again reflected in my research as the reactions of the women immigrants whose expectations are not met vary. Some are quite sceptical and do not fully trust the doctor's diagnosis so get their tests and screenings done in their home country; some go for a second opinion; some take a proactive step and inform their doctors about their medical issues.

7.4.3 GP Attributes

As mentioned earlier in section 7.2.3.2, studies have found that the doctor-patient relationship has become more task-oriented (Bensing, Tromp, van den Brink-Muinen, Verheul & Schellevis, 2006). This may be due to standardised healthcare which is primarily based on guidelines and protocols (Bensing et al., 2006; Reid, 2005). Doctor-patient communication is a multi-dimensional concept that involves medical technical and psychosocial aspects as well as facets of interaction. The study conducted by Butalid et al. (2011) on changes in communication from 1982-2001, show that patients and doctors shared fewer concerns and process-oriented talks such as partnership building in more recent consultations; however, other studies demonstrate that affective behavior with general practitioners is very important to patients (Williams, Weinman & Dale, 1998; Cape & McCulloch, 1999).

This also resonates in my research where some women immigrants feel that their general practitioners take on a more biomedical approach than a biopsychosocial approach. They also feel that the doctors should have more international exposure that would make them culturally more sensitive; on the flip side, some women immigrants feel that their doctors are open-minded and share an accommodating mindset towards medications. Moreover, they also feel that the younger general practitioners are more versant in English, which makes communication relatively easy.

Research (Dutta-Bergman et al., 2005) also states that the doctor should act differently in each case according to the needs and preferences of each patient. This is also partly true in my study as the doctors strive to understand their patients' needs and to accommodate their preferences insofar those preferences comply with the necessary treatment.

7.5 DOCTOR-PATIENT CONSULTATION THEORETICAL FRAMEWORK

Based on the themes that emerged and the discussion conducted in the above sections, I have conceptualised a theoretical framework for the doctor-patient consultation and shown the influence of culture in the entire process.

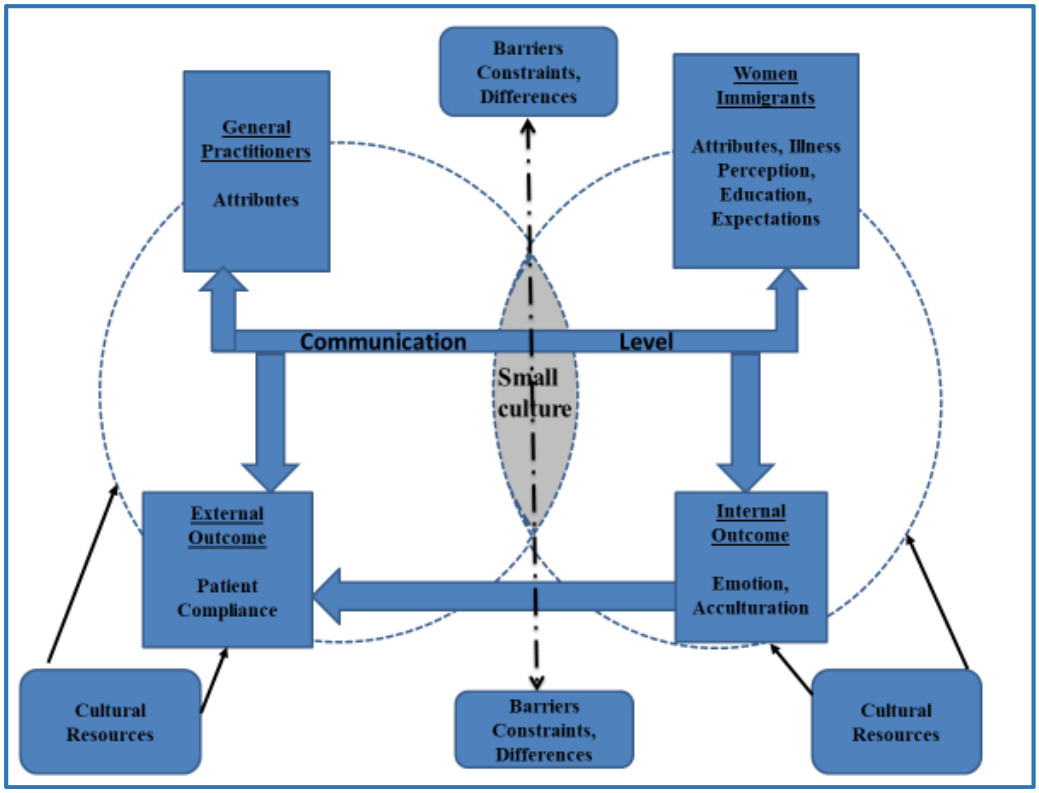

Figure 19: Doctor-Patient Consultation Framework

The general practitioners in the left circle meet with the women immigrants in the right circle in a medical encounter, which is illustrated in grey. Both the general practitioners and the women immigrants influenced by their attributes, illness perception, education and expectations come together in a consultation and communicate with each other indicated in Figure 19 as the communication level. I must add here that in the respective interactants' boxes, I have only listed themes that emerged in my data.

The communication level is central to the internal outcome that takes place within the women immigrants. The kind of interaction the women immigrants face with their general practitioners is decisive as it triggers the respective emotion. The outcome of the medical consultation i.e. if the consultation has been satisfactory or dissatisfactory and has met or has not met their expectations, will trigger the respective emotion, which may be positive, negative, uncertainty or anxiety. In addition to the emotions stimulated, the process of acculturation also plays a role in the reaction and the subsequent action taken by the women immigrants.

The reaction to and action taken based upon the communication level, leads to the external outcome which is the patient's compliance with the treatment regimen prescribed by the general practitioner, who, on the other hand, also decides on the treatment regimen based on the communication with the women immigrant, as well as desires the external outcome –patient compliance, which, however, s/he believes, is the patients' responsibility.

The medical encounter which is painted in grey can be defined as the *small culture* that is formed - a constructed social space that is intersubjective as it is shared by more than one mind (Holliday, 1999) such as the general practitioner and the woman immigrant. It is the process of making and remaking a collective sense of changing social facts (Park, Woodrow, Reznick, Beales & MacRae, 2007). The medical encounter or the small culture formed here is dynamic in nature that forms and changes as required and tries to enable the interactants to make sense of and operate meaningfully in that situation. Interactants come together to form rules and meanings in collaboration with each other (Holliday, 1999).

As mentioned earlier in this section both participants bring in their perceptions and expectations in this social space, however, how rules are interpreted and applied cannot be assumed to be the same for all participants. The interactions constructed in the clinical encounter are bounded by the diverse *cultural resources* illustrated at the bottom of the circles.

Referring to Holliday (1999), it can be said that *cultural resources* are the fundamentals of our lives. Our daily lives are influenced by them. These resources are the respective social, political structures we grew up in, and educated us. They are resources we draw on but are not necessarily confined by them or fully impacted by them in thought and action, although they are omnipresent. This is because each of us with our skills and strategies negotiates our positions within the cultural landscape we belong – a common aspect across all national boundaries. This process of negotiation varies from individual to individual also as we are shaped by our personal trajectories and experiences, which in addition influence that process.

In the medical encounter where the *small culture* is formed, (large and small) cultural realities of both participants meet. The cultural practice and rules form the crux of the small culture. For example, the experiences of both participants are brought in; the commonalities of medical consultations and experiences from all contexts (national, ethnic etc.) make up the building blocks for the new culture.

In addition, routinisation also plays a role in the consultation. Routinisation or establishing routines is where a piece of behaviour is established to a degree that it becomes a normal part of thinking as usual or part of the everyday institutional process of an organisation (Holliday, 2013). Routines and rituals are the core and when small cultures form, they intend to enforce or control the behaviour of others so that it conforms to specific goals. This control function is also a feature of professional groups.

In the case of the medical setting, the general practitioners are mainly in control of the situation owing to their expertise and predominantly set the goal in identifying the illness and prescribing related treatment. Social construction becomes normal and taken-for-granted. For instance, coming straight-to-the-point, accurate description of the illness, etc. are implicit goals laid down by the doctors here. The women immigrants, for instance, are used to longer talks, more patient autonomy, more hygiene standards, less waiting etc.

The difference in the sizes of the two circles indicates the dominance of one group i.e. the general practitioners as they are the experts who control and steer the

communication. Moreover, the medical encounter is at times overshadowed with barriers, constraints and differences. Although efforts such as communication strategies are employed by both interactants, there are linguistic barriers, temporal, procedural, treatment and relational constraints and differences which undermine and aggravate the communication process and may not lead to the envisaged external outcome of patient compliance. These barriers or constraints are indicated with a broken arrow. The broken arrow shows that these impediments occur but can and are at times overcome, too.

The women immigrants bring their everyday experience of small culture formation from their home cultural environment (a GP consultation in their home country) into a new cultural environment, so when they engage in a small culture formation (GP consultation in Austria), they are faced with the small cultural practices found in that new environment.

The cultural practices that operate in the small culture in the new environment Austria may differ and are unfamiliar to women immigrants. As they have this extended experience, they tend to cross-refer the cultural resources between home and the new (Austrian) cultural environments. They try to make sense of the strange practices by comparing them with the familiar ones and by making judgments trying to align themselves with this new "*Other*" (Holliday, 2013). This process of comparing and judging results in dualities where critiquing, contesting of existing cultural practices; struggling to establish or supporting the new practices take place.

The general practitioners also drawn on their *cultural resources* i.e. beliefs, perceptions, values formed in their personal trajectory and professional training. It is at times difficult for the doctors to understand the sense-making schemas of their patients - women immigrants.

These cultural barriers are further compounded by the institutionalised domination of the lifeworld of medicine and the linguistic barriers, thus, creating a divide between the two lifeworlds and cultural realities, which is often difficult to bridge (Mishler, 1984).

The biomedical approach, which prevails as opposed to the biopsychosocial approach preferred by women immigrants; the linguistic barriers that arise through the inability of the participants in being proficient in German or English; stereotyping of the general practitioners; the time restrictions, the treatment and procedural differences all these factors play an underlying role in hindering a smooth and successful interaction. However, these barriers, constraints and differences can be overcome to facilitate a successful interaction to ensure a positive internal and external outcome.

Thus, it can be concluded that the cultural resources play an underlying role in the communication process between the general practitioner and the women immigrant and the aftermath of the medical encounter impacts the internal as well as the external outcome.

7.6 EVALUATIVE RIGOUR

My research conducted in the Austrian context demonstrated immersion into rich and multilayered data. These data highlight the complexity of the doctor-patient interaction, which cannot be reduced and explained through a few isolated variables or in quantitative terms. The voice of my participants, who shared their perceptions with me, made me understand the different views, expectations, communication styles that doctors and patients construct and negotiate during a consultation.

I have tried to complete that complex picture of doctor-patient interaction with a theoretical framework, which could serve as a basis for a better understanding of the interaction and may be employed or worked upon in future research.

7.7 SUMMARY OF CHAPTER SEVEN

In summary, the common themes such as *social security system, communication dimensions* with respective sub- and further sub-themes like *interaction, communication strategies*, *personal connection* and *linguistic barriers*, *consultation context* with related sub-themes such as *time, procedure* and *treatment regimen*, *patient expectations* and *acculturation* have been discussed in detail.

In addition to those common themes, the respective independent themes that appeared in both groups have also been elaborated in detail. These themes are *patients* with sub-themes *illness perception* and *ethnicity*, *patient compliance*, and the sub-theme *GP role* as well as *emotions, immigrant attributes* and *GP attributes*.

The other independent themes such as *patients' education* and sub-themes such as *fear & anxiety*, gender and patients' personality as well as *miscellaneous* and *specialists* have not been dealt with in my study as they were either given scant attention by the participants in their contributions or they are not directly connected to my research. Nonetheless, they are important aspects that should be researched in-depth in the future in the Austrian context.

Finally based on all these findings, I have created my theoretical framework on the doctor-patient interaction pinpointing the complexity of this transaction and have explained how culture plays a key role in influencing the communication process. This framework based on the thick description of the participants may be used in future research in consultations.

8 Chapter Eight Conclusion and Rigour

8.1 INTRODUCTION

This final chapter entails the responses to the three main research questions and justifies the evaluative rigour of the research. It also covers the contributions, limitations and future research possibilities based on this research.

8.2 RESEARCH QUESTIONS

Three research questions have been posed at the beginning of the study. Based on the findings and the discussions explored and explained in chapters 6 and 7 respectively, I have tried to answer the three research questions.

8.2.1 Research Question 1

Which dimensions impact the communication process?

The aim of the consultation process between the general practitioner and the women immigrants is to accomplish the patients' expectations, which is a successful cure of the illness. This is primarily achieved through the communication during the consultation resulting in patient compliance.

Communication is the way humans build their reality. Human worlds are made up of peoples' responses to objects or their meanings and these meaning are negotiated in communication. Communication is more than a simple way to share ideas. It is a process, humans use to define reality itself (Stewart, as cited in Braithwaite & Baxter, 2008, p.4).

Communication is an intentional strategic activity in which people convey internal states to others in the effort to accomplish goals. To be specific, communication is a process, in which a person (source) seeks to convey some internal state to another

(recipient) through the use of sign and symbol - the message in the effort to accomplish some pragmatic end - the goal (Burleson, 1992).

The dyads - the two participants enter into a communicative relationship to recognise and understand the internal state conveyed by the source. Communication occurs to the extent to which the recipient understands the sources' message and the communication can be said to be successful when the recipient responds to the sources' intended message. So, communication proceeds through the four related processes: message production, message processing or message reception, interaction coordination and social perception as explained in chapter 2, section 2.6.

In the case of the clinical encounters experienced by my participants, the communication process is strongly impacted by the interaction per se; the structural, temporal, procedural and the relational dimensions that interplay in the encounter. These dimensions are the most spoken of by both groups, indeed, defined as "*different*", or as "*constraints.*"

Speaking of the interaction, the strongest dimension here is the language, where both interactants experience hindrance in their communication. Since language is the form of expression that both participants employ to make themselves understood to achieve the anticipated goal, its barrier affects health care utilisation as well as treatment of patients (Akhavan et. al., 2013).

The doctors in my research feel in general that they cannot aim at a successful outcome if their patients cannot be understood or can understand them. Despite all the communication strategies they employ like speaking in another language; engaging in drawings; or calling in translators; the doctors are not fully convinced that their intended message has been correctly understood by their patients. Their expectations that patients should be able to communicate clearly and are in a position to describe their problems accurately, are not optimally fulfilled.

On the other hand, referring to my participants the women immigrants, it can be said that many of them do not speak German well. They cannot voice and make their

needs known and as a result become either dependent on others to speak for them or employ various strategies to facilitate successful communication. They try in simple German and speak slowly; try to sensitise their general practitioners by making them aware of their language deficiency; use a combination of German and English in their repertoire; make a list of things (write a script) they want to say and rehearse it in the waiting room.

When referring to the interactional style of the doctors, there has been a paradigm shift from medical paternalism towards patient autonomy in the last 20 years. The notion of patient-centeredness represents the ideal of an egalitarian doctor-patient relationship in which doctors and patients share responsibility for the interaction and its outcomes, thereby taking the perspectives of the patient's need for cure and care (Schouten, Meeuwesen & Harmsen, 2009).

In my study, the interactional style of the doctors varies from paternalistic to patient-centered. The relationship shared between the two also differs accordingly from hierarchical, where the doctors exert more control and make the decisions, to symmetrical behaviour, where the patients' interests such as requests for specific medications or referrals are accommodated in the decision making. Involving the patients in the decision making has led to a positive relationship resulting in a concordance in the management of their disease. However, in cases of a negative relationship, the immigrants either withhold information or change doctors.

The interactional style and the role of the doctor also have an impact on the relational dimension. Although it is patient-centered and the role is said to be symmetrical in nature, the general practitioners' behavior is mainly said to be instrumental. Instrumental behavior consists of giving information on medical/therapeutic issues, asking for clarifications, asking questions about medical/therapeutic issues, counselling on medical/therapeutic issues (Roter & Hall, 1992).

Witte and Morrison (1995) support the view that doctors enculturated in the western paradigm try to determine objectively and rationally physical evidence of illness and expect to be able to fix the patient by making them follow a specific treatment regimen. Such an interactional style of the doctors in most cases has been summed up as "*cold vibe"* (Lara, personal communication, February 06, 2018), *"straightforward"* (Maya, personal communication, August 01, 2018) *and "rushed"* (Prisca, personal communication, February 08, 2018).

Although they feel that they are handled in a mechanical manner, where the dialogue is predominantly based on the medical issue, the respectful and courteous approach of the doctors gives their instrumental behaviour a touch of professionalism (Linda, personal communication, February 05, 2018). Tamara and Letizia, for example, feel that their experiences were very nice and good. Nonetheless, more small talk initiated by the doctors would be strongly appreciated by all my participants of the group women immigrants.

The interaction coordination mentioned above, which involves learning and understanding of the social rules that govern specific interchanges like the biomedical approach in an Austrian medical encounter, structural and temporal aspects are central to producing and comprehending relevant messages.

The structure of the Austrian health care system is by and large good and accessible to all its inhabitants. However, the concept of biomedical medicine is deeply ingrained in the system. This system is gradually opening and acknowledging other forms of medicines, which is also accepted by many general practitioners. The Austrian health care system influences the procedures, where the doctors are predominantly focused on understanding the symptoms and efficiently prescribing cure for the illness given the limited time they have per patient for a clinical encounter.

Moreover, the limited opening hours and non-availability of general practitioners on weekends forcing patients to go to the ER, are structural issues that are

not too well taken by the women immigrants. Sensitivity to requirements such as the presence of female assistants during consultations is not fully acknowledged, yet.

Time is also one of the most pervasive complaints of both doctors and patients. Feeling rushed or hurried is frustrating to both parties. The doctors must bear in mind that the treatment prescribed is effective and economical in monetary terms. In addition to the time constraints, the procedural dimension also influences the communication process.

According to the doctors, the organisational aspect consumes a lot of paperwork and time; moreover, they would appreciate spontaneous and regular professional translation services to facilitate an unproblematic consultation procedure. Furthermore, the structural and procedural differences in the various health systems that the immigrants are familiar with, add to the complexity of the interactional situation as they are attuned to different health care systems and different consultation procedures.

My research also shows that an aspect of the "*dual frame of reference*" Suarez-Orozco (1989), where the women immigrants accept treatment without questioning the quality of care, is not the case. Indeed, a few succumb and accept the situation; some change the doctors; or try to employ the numerous strategies mentioned above and earlier in chapters 6 and 7, to combat differences and derive a beneficial outcome from the consultation.

Hence, it can be said that both interactants try to adapt their behaviour the women immigrants perhaps more than the general practitioners in response to the communicative action of the other interactant to establish a smooth and effective interaction as well as to reach mutual agreement to achieve the anticipated goal despite the interactional, structural, temporal, procedural and relational differences that influence the communication.

8.2.2 Research Question 2

What role, if any, does culture play a role in the communication process?

Referring to my theoretical framework Figure 19, devised on the doctor-patient interaction, I have tried to highlight how culture plays a role in the entire consultation process.

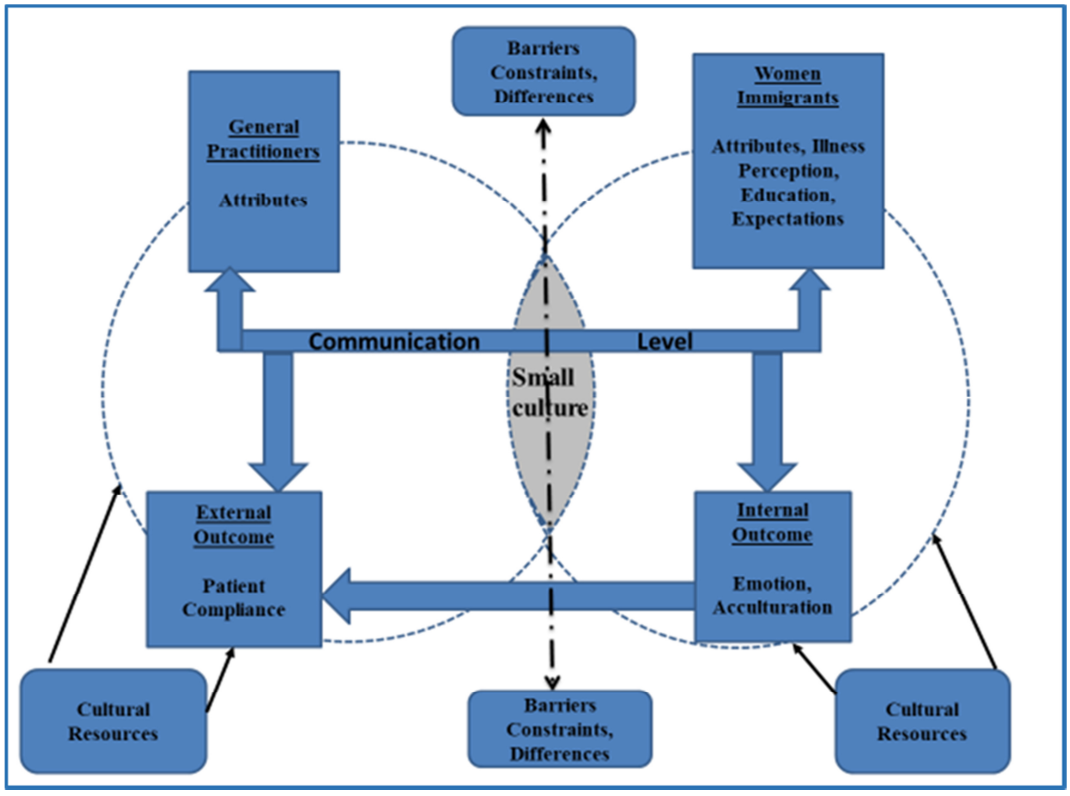

Figure 19: Doctor-Patient Consultation Framework

Based on this framework, which has been explained in detail in section 7.5, it can be inferred that both participants are shaped by their attributes, perceptions as regards illness, education and expectations, which play a role during the consultation. As mentioned in the previous section, the communication between the two interactants is of underlying importance to facilitate a positive (external) outcome which is patient adherence to the treatment regimen.

The communication in a medical encounter evokes emotions in the women immigrants and that, in turn, influences the outcome of the consultation. In addition to the emotions, acculturation also impacts the outcome. The doctors, on the flip side, also strive to attain and encourage the external outcome, which is patient compliance.

The medical consultation is a social space constructed and shared by both participants where they make sense of, act and react in that situation by forming rules to collaborate. This social space is referred to as *small culture* as defined by Holliday (1999). *Small culture* is more to do with the activities/interaactions taking place within a group than with the nature of the group itself.

Furthermore, the interactions are governed to some extent by the diverse *cultural resources* that form the fundamentals of individuals' lives (Holliday, 1999). These *cultural resources* are each individual's personal trajectory that s/he draws on or is impacted by to a varying degree. The national culture, education, language, ideologies of each individual as well as personality, the skills and strategies s/he use to navigate in the small culture shape the cultural realities of my participants.

In addition, routinisation also plays a role in the consultation i.e. in the *small culture* formed as they intend to enforce or control the behaviour of others so that it conforms to specific goals. This control function is also a feature of professional groups. In consultations doctors mainly control the situation owing to their expertise and predominantly set the goal in identifying the illness and prescribing related treatment. Social construction becomes normal and taken-for-granted for both participants. For instance, coming straight-to-the-point, accurate description of the illness, etc. are implicit goals laid down by the doctors. The women immigrants, for instance, are used to longer talks, more patient autonomy, better hygiene standards, less waiting etc.

Moreover, the medical encounter is at times hindered with barriers, constraints and differences. Although efforts, as explained in chapter 7, such as communication strategies are employed by both interactants, there are linguistic barriers, temporal, procedural, treatment and relational constraints and differences, which undermine and

aggravate the communication process and may not lead to the envisaged external outcome of patient compliance. Nonetheless, these impediments can and are at times overcome.

As I have mentioned in the previous chapter 7, that literature in the field of health communication often state that patients from minority groups, immigrants face disparity in health care treatment and the utilisation of health care services often caused due to various aspects, where large and small culture are said to be important aspects. Referring to Holliday's (2013) illustration on the cultural travel in Figure 20, I would like to elaborate on how culture plays a role in the consultation process.

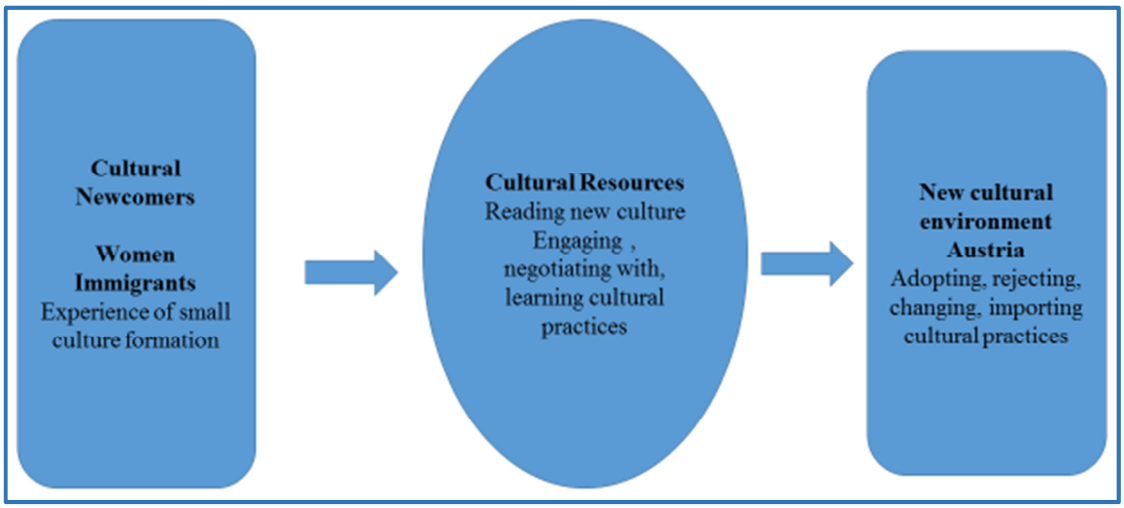

Figure 20: Cultural Travel
Source adapted Holliday (2013)

The left rectangular shape in Figure 20, represents the newcomers i.e. the women immigrants and the *small culture* formations, which they live daily. The right rectangular shape is the new cultural environment Austria travelled to where they bring with them their *cultural resources* shown in the round shape in the centre. The women immigrants bring along their everyday experience of *small culture* formations from their home cultural environment (a GP consultation in their home country) into a new cultural environment in this case to Austria, where when they engage in a *small culture* formation (GP consultation in Austria), and there they face small cultural practices found in that new environment.

The cultural practices that operate in the small culture in the new environment Austria may differ and may be unfamiliar to the women immigrants. As they have this extended experience, they tend to cross-reference the cultural resources between home and the new (Austrian) cultural environments. They try to make sense of the strange or unfamiliar practices by comparing them with the familiar ones and by making judgments trying to align themselves with this new "*Other*" (Holliday, 2013). This process of comparing and judging results in dualities where critiquing, contesting of existing cultural practices, struggling to establish or supporting the new practices take place. This can be seen also in my research where five women immigrants resist and contest the existing cultural practices and struggle in supporting the new practices, whereas eight women immigrants face struggles but confirm and support the new practices.

Likewise, general practitioners draw on their *cultural resources* i.e. beliefs, perceptions, values formed in their personal trajectory and professional training. It is at times difficult for doctors to understand the sense-making schemas of the women immigrants. The patients' lifeworld narratives are organised by their *cultural resources* and sense-making schemas and they resort to their sense-making schemas to organise and tell their stories, which can be difficult for doctors to understand.

Moreover, patients "*mix and match*" their schemas and sometimes add new ones as they face clinical encounters as also seen in Figure 20. Given that cultural schemas and orientations are multiple, hybridised and adaptable, doctors cannot possibly know a priori the patients' lifeworld, so they must learn it by orienting themselves towards careful communication (Connelly, 2005).

In my research, doctors mainly control the consultations, where in most cases the biomedical approach dominates, thus, reducing the patients' lifeworld into a diagnosis of symptoms and treatment options. The doctors have to deal with two sets of sense-making frameworks, which are translating between health systems and bridging divergent images of medicine, which is indeed a challenging task.

Women immigrants, on the other hand, bring with them their health concepts, expectations of treatment procedures or norms of clinical interactions - their *cultural resources* - so doctors have to find strategies to translate these familiar concepts and practices into the Austrian health system. The general practitioners try their best to move from the standard practice and listen to the patients' voice to some extent but this should be done to a greater extent.

In addition, experiences with specific health behaviours of individuals belonging to the same ethnic group have led doctors to assume that these apply to all members identified with that same background. They tend to predict, differentiate and also label certain traits and values that do not fit as exceptions. This, in turn, influences some doctors' socio-cultural attitude and communication styles.

All these aspects, for instance, the dominating biomedical approach than the biopsychosocial approach, the linguistic barriers that arise through the inability of the interactants in being proficient in German or English; the stereotyping of the interactant, the time restrictions, the treatment and procedural differences, that play an underlying role in hindering a smooth and successful interaction, can be found in my study.

However, these barriers, constraints and differences can be overcome to facilitate a successful interaction to ensure a positive internal and external outcome. Thus, it can be concluded that cultural resources play an underlying role in the communication process and the aftermath of the small culture impacts the internal as well as the external outcome.

8.2.3 Research Question 3

Does medical interaction impact women immigrants' illness management?

Studies in the field of intercultural health care communication show that patient satisfaction correlates to patient compliance. The way general practitioners communicate with patients determines patient satisfaction. Patients tend to rate their level of satisfaction higher when the physician provides them with the desired amount of information regarding their medical problem (Tasso et al., 2008; Blanck, Rosenthal & Vanicelli, 1986; Comstock, Hooper, Goodwin & Goodwin, 1982; Hall, Roter & Katz, 1988).

Similarly, patients tend to adhere to their treatment programmes better when they are satisfied with their medical care (Tasso & Behar-Horenstein, 2008; Cole & Bird, 2000; Roter & Hall, 1992; Servellen, 1997). Patient compliance is considered an indicator of the effectiveness of physician-patient communication (Ong, Haes, de Hoos & Lammes, 1995).

Based on my data, it can be inferred that patient satisfaction is given among some of my women immigrants despite struggles, whereas some of them express stronger discontent with the structural, temporal, procedural and relational aspects. Some women immigrants expressed positive emotions or uncertainty; a few express themselves to be anxious or negative in their outlook towards their medical encounters. Many of the women immigrants feel that they can speak freely and openly with their doctors. They can express their concerns and the doctors show willingness in providing more information. They feel safe and secure and trust their general practitioner. The reactions of my participants vary. They are supportive or show resistance to the Austrian medical practices depending on the cultural realities they face.

As most of the women immigrants have been living in Austria for a fairly long period, acculturation kicks in and they have started coming to terms with the consultations. By and large, they have learned to accept the situation, or go for a second opinion or seek advice from the doctors in their home country; sometimes, they feel it is a

waste of time of trying new doctors and have given up trying to change the situation. In general, they are aware that they cannot go to the doctor's here with the same expectations as in their home country for this makes the interaction difficult and things may or tend to go wrong.

Although all the women immigrants are educated and have been living here for less than 10 years, and are by now familiar with the Austrian health care system, it is wrong to assume that higher educational level and longer residency will help them to navigate better in the Austrian healthcare system and understand its underpinning beliefs, values and assumptions. According to Berry (1997) acculturating people can develop host cultural practices while maintaining their heritage cultural practices at the same time. This seems to be the case too in this research where the perceived consultation differences still strongly prevail among some women immigrants and when possible tend to seek advice from doctors in their home countries.

Despite consultation issues, all women immigrants seem to adhere to their treatment options to a great degree. This question was not directly asked but it can be inferred that they certainly are conscious of their health and wellbeing and if their needs are not fulfilled here, they reach out for advice in their home countries. Thus, it can be said that although in general a successful consultation catalyses patient compliance, this is not clearly indicated in my research. It can be implied that despite the struggles and the varied reactions of my participants, they seem to be concerned about their health and their illness management.

8.3 EVALUATIVE RIGOUR

The four criteria credibility, transferability, dependability and confirmability introduced by Guba and Lincoln (1994) and subsequently the additions of Leininger (1985) meaning-in-context, recurrent patterning and saturation have been precisely followed in my study to display and confirm its trustworthiness.

8.3.1 Credibility

Credibility refers to the truth and accuracy of the findings. It aims at demonstrating if the explanation of the researcher fits the description and if the description is credible. Member checks, intra-reliability, audit trails are ways of showing credibility.

As explained all along, the data gathering during the interviews has been mutually determined by me and the participants to be accurate. They have been audio-recorded to obtain accuracy, too. Moreover, those interviews also indicate a credible representation of the participants' knowledge and experiences. Participants were asked for clarification during the interview, which on one hand, elicited further information, on the other hand, also validated the content of their statements.

Member checking has not been carried out in my research with every participant. All participants were informed to contact me if they wanted to read through their respective transcripts, which was done by two participants WI_BDL_06 (Dana) and WI_AI_08 (Maya). I was also permitted to contact for clarification. This was not essential as the overall message has been clear in all interviews. A few doctors have requested a summary of the entire research. This will be forwarded once permitted.

The soundness of the findings and conclusions is important to interpret the term validity in a more comprehensive way (Gibbs, 2007). For this intra-reliability with the help of a colleague in the thematic analysis process was conducted. This encouraged not only the iterative process but also gave validity to my categorisation method. In this manner, I could also safeguard against personal biases and support the consistency and

congruency of my work. Sharing the interpretation of data with colleagues provides an invaluable opportunity to challenge the robustness of the emerging themes.

Consistency and congruency have also been derived with the interview guides for each group. In addition, I reviewed each transcript and ensured that consistency and accuracy have been maintained. Reliving the interviews helped me add some comments in hindsight to my memos. Lastly, working every two or three days on my coding supported accuracy and consistency due to this distance and closeness process.

Credibility can be enhanced by the construction of an audit trail (Koch, 2006; Meyrick, 2006; Rolfe, 2006; Sandelowski, 1986; Smith, 1999; Wolf, 2003) a means of tracking all decisions that are made throughout the research process (Koch, 2004). Each step data collection, the six phases of thematic analysis; the Mayring and KWIC approaches have been strictly followed in the thematic analysis and coding process, accordingly. In addition, the transcripts, the coding frame, the codebooks, matrix query coding tables and charts, my reflective journal, as well as the direct quotes are examples of the audit trail.

8.3.2 Transferability

Transferability is comparable with external validity and refers to the generalisability of the inquiry. Transferability suggests that findings from the study can be transferred to another similar context or situation without losing the meanings and interpretations (Leininger, 1985).

To provide detailed descriptions as regards the transferability of the findings to the specific contexts, I tried to create "*thick descriptions*" including the accounts of the context. In chapter 6, I have followed the recommendation to generously use participants' quotations to provide contextual and unbiased evidence of participants' rich descriptions of their experiences. In addition, the transcripts, memos written after each interview can also be found in the section Appendices 11 to 13 and 19.

8.3.3 Dependability

Dependability is comparable with reliability and is achieved through the process of auditing and reflexivity, which is central to the audit trail. According to Guba and Lincoln (1994) when dealing with the consistency of data, audibility is recommended as a criterion for rigour. My audit trail and reflective journal describe explicitly my decisions taken on the theoretical, methodological and analytical choices throughout my study. See excerpt of the reflective journal in section Appendices 20.

Dependability is often compared to the concept of reliability in quantitative research and refers to how sTable the data are (Graneheim & Lundma, 2004; Rolfe, 2006; Tobin & Begley, 2004). Matrix coding queries helped in comparing multiple nodes as a numeric Table, where the number of participants referring to that respective issue becomes evident. I could also inspect whether too many units of coding are assigned to one code. In a similar vein, the codes are drawn on the validity criteria of unidimensionality, mutually exclusiveness, exhaustiveness and saturation. The codebook also indicates the well-distinguished differentiation between the codes and the reliability and credibility of the coding process. Lastly, reflexivity central to the audit trail is dealt with in further detail in section 8.3.6.

8.3.4 Confirmability

Confirmability refers to reaffirming what the researcher has seen or heard with the phenomena under study (Leininger, 1985). The measures stated above that affirm credibility also support confirmability. This defines the process and how the interpretations have been arrived at. The confirmability can be deduced through the direct quotes in chapter 6. As the other three criteria have been fulfilled, it can be said that this criterion has also been accomplished.

8.3.5 Additional Criteria

The following three criteria set by Leininger (1985) have also been fulfilled.

Meaning-in-context relates to the significance of taking into account the value of the situation, event or experiences to the participant (Leininger, 1985). The open-ended questions and the good rapport with the participants primarily encouraged them to narrate their experiences in much detail as possible. The interviews transcribed in verbatim so not just content (What) has been taken into consideration, but also the context of the participants' circumstances and experiences (How). Pauses and emotional aspects such as laughter have been included also denote the reliability of the work. See section Appendices 11 to 13.

Recurrent patterning according to (Leininger (1985) are the repeated experiences, expressions and activities. Themes, for example, reflect the recurring patterns. For example, graphical displays in section 5.2.6 to better understand and explain the salient themes that emerged; compare the relationships shared between the categories and gain the broader picture.

Saturation refers to the exhaustive exploration of the subject and no further insights are forthcoming from the participants (Leininger, 1985). Saturation has been reached on two levels in the interviews. During the interviews, participants spoke till they felt that they had nothing more to narrate and secondly, interviews have been conducted till I had the feeling that duplication of content with similar views and expressions was being produced. Lastly, the criterion of saturation for the coding frame as explained earlier has also been followed.

The following Table 19 sums up the respective research strategies and operational techniques applied in my study. Inspired by the table created by Tuckett (2005), I have also shown in this table the positivist rigour criteria, the equivalent qualitative rigour criteria for trustworthiness and evaluation criteria by Guba and Lincoln (1994) and the criteria for rigour by Sandelowski (1986).

Criteria for rigour and the equivalent terms					
Rigour Criteria	**Trustworthiness**	**Evaluation Criteria**	**Criteria for rigour**	**Research Strategy**	**Operational Techniques**
Internal Validity	Credibility	Credibility	Truth value	Reflective journal, Audio recordings, Transcripts, Memos on interviews	Purposeful sampling, Intra-reliability / Peer debriefing, Audit trail, codebook
External Validity	Transferability	Fittingness	Applicability	Data Display, Literature Review	Purposeful Sampling, Thick description – Quotations of participants, participant protocols with demographic details and data files
Reliability	Dependability	Auditability	Consistency	Audio Recordings, Transcripts, Memos on interviews, Reflective journal	Peer debriefing / Intra-reliability Audit trail, matrix and code queries; reflective journal
Objectivity	Confirmability	Confirmability	Neutrality	Memos	Audit trail matrix and code queries, reflective journal

Table 19: Criteria for Rigour based on Guba, Lincoln and Sandelowski

8.3.6 Reflexivity

Reflexivity is said to establish criteria of rigour, which increases the confidence, congruency and credibility of findings (Bishop & Holmes, 2013). It improves transparency in the researcher's subjective role when conducting research and analysing data and allows the researcher to apply the necessary changes to ensure the credibility of his/her findings (Ballinger, 2008; Finlay, 2003) and is central to the criterion dependability.

My reflective journal contains notes on the most important aspects and issues that I have experienced. For example, research idea, my objectives for research and my introspective findings in the scope of this research. My thoughts, assumptions, changes,

challenges, doubts and decisions have been penned in this journal. See excerpt of the reflective journal in section Appendices 20.

Reflexivity is also a process that considers the mutual influences of the researcher and participants on each other. Both researchers and participants have a subjective influence on the research process and its findings (Houghton, Casey, Shaw & Murphy, 2013).

The proximal arrangement, chit chat put women immigrants at ease during the interview and created a free and open atmosphere for asking and answering questions. Likewise, there was a friendly atmosphere with the doctors because they were keen on explaining their viewpoints to me. A good rapport was established with all participants before, during and after the interview.

Intra-reliability ensured a clear and "*clean*" research process; to avoid any kind of misinterpretation of the participants' accounts or biases. Moreover, the interpretations of the findings are strictly based on evidence i.e. I have quoted the participants in every account as suggested by scholars (Jootun, McGhee & Marland, 2009).

Transparency as an important part of reflexivity, can be traced through the audit trial. For instance, the memos written at the end of every interview and during the thematic analysis. See excerpts of memos in section Appendices 19. Furthermore, I have summed up the outcomes of my reflexivity in Table 20 below:

Context of reflection	Trigger of reflexivity	Introspective process	Outcomes of reflexivity
Literature review	Not convinced of the essentialist approach	Felt frustrated initially as was not convinced that culture is only related to nationality	Read a lot till I found the small culture concept a concept I could relate to and decided to connect it with my research idea.
Pilot phase interviews of women immigrants 3 and 4	I asked specific questions about culture	As a novice interviewer, I did not realise when I asked them this question that I was unintentionally misleading them.	I rephrased the specific questions asked in the first interview and interviewed them again just on those parts; however, didn't feel comfortable about it and omitted these two participants completely in the analysis. Was a lesson learnt as did not make this mistake again in all forthcoming interviews.
Pilot phase interviews of GPs 1 and 3	I asked specific questions about culture and also some irrelevant probing questions.	A novice interviewer and asking questions in German so sometimes they were, without any intentions, not formulated as open questions.	Rehearsed the questions in the interview guide several times before the interview as well as the probing questions in my mind during the interview before I asked them.
Interview with GP Sebastian	He spoke too much in detail with background information and digressed from the topic at times..	It was difficult to constantly pay attention as the interview was too long and was held after a long day's work in the evening; it was informative but was not too easy to get him back on track.	His eagerness and motivation to respond made me realise that it was important to get details from the participants to understand their perspectives and not for the sake of getting details
Disinterest of WI - Irene	She seemed forced and disinterested during the interview	The probing questions also did not help much; should have rephrased them better to elicit more information	To be more adaptable and spontaneous in formulating probing questions in the future;

To remind participants (WI) about the topic.	Participants often spoke of doctors in general sometimes were blurred with examples as they spoke of specialists.	Every question was related to experiences with GPs, so felt uncertain if participants referred to their GP all the time.	Had to constantly remind the participants that it was only about GPs. Ask the same question at times again referring to their GP, if I was uncertain of their references in their responses.
To remind participants (GPs) about the topic.	Participants often spoke of immigrants in general sometimes were blurred with examples as they referred to people (Personen) or human beings (Menschen) or Patients (Patienten). In German there are different forms for gender and the doctors referred to the masculine form.	Every question was related to experiences with women immigrants so felt uncertain if participants referred to their female patients all the time.	Had to often remind the participants that it was only about female patients. Could not ask the same question at times again for reassurance that they are referring to their female patients, when I felt uncertain due to time limits. I assume they generally did refer to female patients as sometimes they specified and said no gender differentiation is made in health issues.
Questions sounded repetitive in German at times	Sometimes got the feeling that participants felt that the questions were similar and repetitive in nature.	Felt that the participants need to be reassured that I am not looking for a certain specific response; felt I should rephrase the questions better.	I did not rephrase the questions as they served as elaboration on the topics of research; I stressed prior to the interview and after the interview that I was looking for their perspectives.
Use of *I* in the research	I was not inclined to use *I* in the research at all. Am still hesitant to use it throughout the research.	Felt it would be too much using the personal pronoun and would damage the style of writing.	Decided to use it mainly in the methodology and discussion as well as in this chapter as am "*actively*" – hands-on participating, whereas to make minimum or no use in the first two chapters as I was dealing with a lot of reading and in-depth understanding of the topic.
Go back to literature	Findings affirmed to a great extent but also challenged some of my material	Had to do some more reading in the field of relational aspects and role of GPs	Had to go back to literature and do more critical reading in the fields challenged.
Translation of the German transcripts	I feared that my translation may have an impact on the findings.	The Tyrolean dialect and accent could lead to misinterpretation and influence the findings.	All translated transcripts have been reviewed by my colleague who is from this region and works in the sector of health care. In this manner my subjectivity was contained.
Coding	I coded, re-coded and thought that I had my themes and sub-themes but had difficulties when writing my discussion chapter.	The discussion chapter made me rethink my coding as I initially could not find a proper structure for that chapter due to the coding.	I then re-clustered my themes into common themes and independent themes that gave my chapter a clear structure.

Table 20: Outcomes of Reflexivity in my Research Process

Reflexivity has enhanced my self- awareness. I have gained new perspectives about the Austrian health care situation. I also became aware of my behaviour in clinical encounters and could put it into context owing to this research. Surprisingly, my findings are in line with various research results conducted in this field worldwide

In addition, "*stepping back from the data*" (Probst, 2015) during the data analysis process has been a helpful counterweight to the tendency of becoming over immersed. I had extensive data and analysing them appeared to me as an insurmountable task. Regular breaks gave me the distance and helped me modify some codes. See section Appendices 20.

In a nutshell, qualitative studies are prone to subjectivity. My trajectory of subjectivity evolves from the position of a distant observer through personal experiences when I accompanied women immigrants to doctors' visits during voluntary work; reader to an embodied explorer participating actively with my interactants that I underwent during the entire process of researching on this topic, interviewing my participants; and personally integrating to understand the concepts as well as to become the co-creator of this research.

Finally, the credibility of my research also strongly rests on reflexivity i.e. the personal contributions, the self-awareness, the challenges faced and decisions taken throughout the research process, which I have expressed in my reflective journal.

8.4 ETHICAL MINDFULNESS

Etherington (2007) emphasises ethics as a balancing act "*between our needs as researchers and our obligations toward care for, and connection with, those who participate in our research*" (p.614).

In addition to the informed consent from all participants, consent from the University Ethics Committee and from the various responsible Austrian stakeholders was acquired. See section Appendices 3-6.

Participants' autonomy has been fully respected. Participation has been voluntary and participants could withdraw at any time of the study. I also adhered to the principle of justice, where the needs of the participants come first before the objectives of the research. The participants were not coerced or made to feel obliged to take part in this research, nor did they face any compulsion to answer all questions. The principle of beneficence has also been ensued; no harm or malfeasance came to the individual due to participation.

Confidentiality and anonymity have also been strictly maintained throughout the research. The data are stored with alphanumeric numbers and participants have never been addressed with their full names during the interviews; on occasions only with their first names at the beginning of the interview, this refers only to the women immigrants. The doctors have never been addressed with their names but occasionally with their title "*doctor*". The transcribers were only given the alphanumeric number of the participant. They also had to sign a non-disclosure agreement.

8.5 CONTRIBUTIONS AND FUTURE RESEARCH

This study would serve as a basis for further research in this region where the racial landscape is consistently changing.

The Austrian health care system is excellent but there is substantial room for improvement when it comes to utilisation of health care services in view of immigrants. So far research has been carried out with specific ethnic groups and this is the first kind of research where participants from diverse national backgrounds and not only from any specific ethnic groups or national backgrounds have been interviewed with the intent to understand what women immigrants in general think of their medical encounters.

Furthermore, in my research, I have explored and analysed both participants of the medical consultation to give a holistic picture of the small culture formed in a medical setting. The fact that both voices have been heard is a salient feature of my study.

Both participants groups were asked for their opinion about patients – women immigrants or general practitioners. No specific patients nor general practitioners were targeted at. This approach of not interviewing the respective doctors of the women immigrants and vice versa helped in gaining multifarious opinions on both groups. These diverse views depict a broad and intricate web of the struggles, skills and strategies they employ during a medical consultation. Also, this study illustrates the diverse cultural realities that shape the medical interactions as well as highlights the complexities of such interactions.

Moreover, I think this study paves the way for further in-depth research covering a bigger population of women immigrants. A comparison between women immigrants and autochthonous female population would also be of interest as it would help researchers, stakeholders as well as participants involved to understand the situation better and propel changes that would be beneficial to all.

This research may help doctors in adapting their consultation process since the general practitioners serve as "*gatekeepers*" and play a decisive role in further actions such as referrals, etc. Also, for prospective medical doctors, intercultural communication in health care could be a mandatory course in their education. For women immigrants this would help them understand the Austrian medical situation better, thus, preparing them to navigate in an unfamiliar health care system and consultation.

Furthermore, understanding the role of culture leads to insights into ways to improve women immigrants' access to health care, compliance and satisfaction, on the other hand, it also serves to clarify the disjuncture between the perspectives of patients and general practitioners. This may increase cultural sensitivity and awareness amongst participants and result in more effective intercultural medical encounters.

The invaluable insights pinpointed by my research through the dominant and less dominant themes are of significance to the region. Since the less dominant themes have not been addressed, they could be looked into in detail in further research.

Lastly, conducting this research over a period of six years has enhanced my personal development. My trajectory of subjectivity evolves from the position of a distant observer, reader, to an embodied explorer participating actively with my participants and personally integrating to understand the concepts as well as in becoming the co-creator of this research.

8.6 LIMITATIONS

All the women immigrants I contacted are coincidentally educated women. This could be because most of the contacts have been through friends and colleagues and this snowball sampling proved to be most effective despite postings on social media or in social organisations. Thus, the group of women immigrants interviewed belong to a stratum of society.

The general practitioners have been mainly from Innsbruck and just two from the periphery of Innsbruck. These peripheral cities also host quite a dense mixed population, so some more participants from these regions would have been interesting. All the interviews have been held in German, which were translated into English. The loss of information cannot be fully ruled out.

As mentioned earlier in Table 20, the women immigrants digressed at times and referred to specialists. I had to constantly remind them of general practitioners, however, I cannot affirm that they only referred to their general practitioners all the while.

Likewise, the doctors spoke of patients – immigrants in general and I also had to constantly remind them of women immigrants and here too, I cannot confirm that they exclusively spoke of women immigrants all the time. Moreover, the term *"women immigrants"* conjures different labels in the minds of the general practitioners which based on the interviews can be inferred as women with less German proficiency, less informed or aware of the Austrian health care system which matches only partly with my group of participants – the women immigrants.

The doctors and the patients interviewed may not be familiar with each other. I did not interview the general practitioners of my women immigrants nor did I speak to those patients - women immigrants of the doctors interviewed. This may have led to a deviant image of women immigrants as well as of general practitioners at times.

Finally, time was also a factor for the doctors. They were very kind and accommodating but despite the time dedicated to my interviews, I could sense that they were busy. Thus, I made sure that all the questions in the interview guide were answered and when time permitted, I clarified some statements or I requested them to elaborate on some statements made. Unfortuately, it was not possible to delve and probe into all vital remarks made by them during the interview.

8.7 SUMMARY OF THE CHAPTER

The three research questions have been answered where I have highlighted how the interactional, structural, temporal, procedural and relational differences influence the communication process in a medical consultation. I have also explained in detail how the cultural resources of individuals have an influence on the communication with the help of my theoretical framework as well as attempted to understand to what extent patients' compliance impacts their illness management.

Evaluative rigour and ethical mindfulness have been taken into consideration from the initial phases of my study and are manifested throughout my research. Lastly, despite limitations, this research serves as an invaluable contribution to the Austrian medical setting. It lays the basis for further research on themes that emerged; it also gives food for thought for not only prospective research topics but also aims to raise awareness among interactants helping them to adapt their communication processes or preparing them for consultations.

8.8 CONCLUSION

This research presents the social reality in a medical encounter in the Tyrol, Austria. It concentrates on understanding and elucidating how women immigrants and general practitioners construe and negotiate meanings in medical interactions in the doctor-patient medical setting. Furthermore, this qualitative study investigates the role culture plays in the communication process as well as how experiences of women immigrants in a consultation influence illness management.

Analysis of thirteen women immigrant interviews show that they had faced a mixed range of positive to negative experiences. In most cases they are content with their doctors despite communication, temporal, structural, procedural and relational constraints. Likewise, analysis of eight general practitioner interviews shows a mixed range of experiences. They primarily found linguistic barriers to be a major challenge in diagnosing and advising treatment and the time constraints that do not allow deeper individual attention to patients.

Moreover, cultural elements impact the consultation to a great extent. The *cultural resources*, which are connected to national identity, personal trajectories, influence the consultation. However, the relationship to these *cultural resources* is not fixed nor easily predictable. This notion should be understood and borne in mind by both interactants when they meet and form their small culture i.e. in the medical setting.

Moreover, the two different approaches - biomedical and biopsychosocial that emerge in the clinical encounter, are incongruent in nature and often lead to communication discordance. This is further pressed by linguistic, relational, structural, procedural and temporal obstacles which make it hard for both interactants to keep up with their expectations. Patient expectations and satisfaction, in turn, impact the patients' behaviour. Thus, it is important to create a linkage between these two approaches to avoid discordance in the clinical encounter.

Despite endeavours from both participants, communication has at times not been as successful as expected during consultations. The doctors try their best to understand their patients and provide equal treatment to all. They generally tend to follow the same procedure for all patients, which is not successful in all consultations. They try to make sense of the communication in most cases based on patients'national identity. The women immigrants, on the other hand, react differently to difficult consultation situations. They either tend to be proactive or resign themselves to the situation or get the check-ups done in their home country.

A good relationship between doctor and patient is essential for effective care. It is important to identify the obstacles for patients; build interpersonal influence through non-verbal behaviour, engage in active listening; and show empathy. There is no pre-packaged answer for establishing a good rapport. It must be developed on an individual basis. A *"one-size-fits-all"* approach cannot lead to beneficial outcomes.

This study conducted over six years also fulfils the aims and the objectives set at the beginning of the research in section 1.3. In addition, the evaluative rigour as its trustworthiness can be trailed throughout the study. Reflexivity also strongly contributes in meeting the criteria in qualitative research. Furthermore, ethical considerations have also been followed strictly and met.

Lastly, this research contributes in giving an insight into the current situation in Innsbruck and its surroundings and paves the way for further prospective research. These insights may inspire better communication skills and culturally sensitive communication in educational programmes to increase successful interaction between the doctors and patients.

The shift of focus from objective consultations to more on patient-centeredness as well as affective dimensions of care such as rapport building will benefit patients. Furthermore, these insights may also empower patients by helping them to adapt their communication processes or preparing them for consultations.

Last but not least, the ultimate aim is to raise awareness among both participants such that through good communication and mutual agreement between these interactants, optimal utilisation of health care services and treatment is enabled.

9 References

Aamodt, A.M. (1986). Discovering the child's view of alopecia: Doing ethnography. In P. L. Munhall & C. J. Oiler (Eds.), *Nursing research: A qualitative perspective* (pp.163–172). Norwalk: Appleton-Century-Crofts.

Aamodt, A.M. (1991). Ethnography and epistemology: Generating nursing knowledge. In J. M. Morse (Ed.), *Qualitative Nursing Research: A contemporary dialogue* (pp.40–53). Thousand Oaks, CA: Sage.

Abraído-Lanza, A.F., Echeverría, S.E., & Flórez, K.R. (2016). Latino immigrants, acculturation, and health: Promising new directions in research. *Annual Review of Public Health*, *37*, 219–236. https://doi.org/10.1146/annurev-publhealth-032315-021545

Adams, C. (2006). PowerPoint, habits of mind, and classroom culture. *Journal of Curriculum Studies*, *38*(4), 389–411. https://doi.org/10.1080/00220270600579141

Agar, M. (2009). Themes revisited: Some problems in cognitive anthropology. *Discourse Processes*, *2*(1), 11–31. https://doi.org/10.1080/01638537909544451

Agledahl, K.M., Gulbrandsen, P., Førde, R., & Wifstad, Å. (2011). Courteous but not curious: How doctors' politeness masks their existential neglect. A qualitative study of video-recorded patient consultations. *Journal of Medical Ethics*, *37*(11), 650–654. https://doi.org/10.1136/jme.2010.041988

Ahmadi, Y., Shahmohamadi, A., & Araghi, M. M. (2011). The study of e□ect sociocultural factor on cultural intelligence. *International Journal of Humanities and Social Science, 12*, 161–168.

Aitini, E., Martignoni, G., & Labianca, R. (2014). Communication models for doctor-patient relationships. *Journal of Cancer Education: The Official Journal of the American Association for Cancer Education*, *29*(2), 211–212. https://doi.org/10.1007/s13187-014-0616-z

Akhavan, S., & Karlsen, S. (2013). Practitioner and client explanations for disparities in health care use between migrant and non-migrant groups in Sweden: A qualitative study. *Journal of Immigrant and Minority Health*, *15*(1), 188–197. https://doi.org/10.1007/s10903-012-9581-y

Ali, N., Atkin, K., & Neal, R. (2006). The role of culture in the general practice consultation process. *Ethn Health, 11*(4), 389-408. PMID:17060034

Allport, G.W. (1979). *The nature of prejudice*. Reading, MA: Addison-Wesley.

Altman, D.G. (1995). *Practical statistics for medical research*. London: Chapman & Hall.

Andersson, J., Salander, P., Brandstetter-Hiltunen, M., Knutsson, E., & Hamberg, K. (2008). Is it possible to identify patient's sex when reading blinded illness narratives? An experimental study about gender bias. *International Journal for Equity in Health*, *7*, Art. 21. https://doi.org/10.1186/1475-9276-7-21

Arasaratnam, L., & Banerjee, S. (2007). Ethnocentrism and sensation seeking as variables that influence intercultural contact-seeking behavior: A path analysis. *Communication Research Reports, 24*, 303–310.

Aries, E. (1998). Gender differences in interaction: A reexamination. In D. J. Canary & K. Dindia (Eds.), *Sex differences and similarities in communication: Critical essays and empirical investigations of sex and gender in interaction* (pp.65–81). Mahwah, NJ: Lawrence Erlbaum Associates.

Aroian, K.J. (1990). A model of psychological adaptation to migration and resettlement. *Nursing Research*, *39*(1), 5–10. https://doi.org/10.1097/00006199-199001000-00002

Aroian, K.J., Spitzer, A., & Bell, M. (1996). Family stress and support among former Soviet immigrants. *Western Journal of Nursing Research*, *18*(6), 655–674. https://doi.org/10.1177/019394599601800604

Ashbury, F.D., Iverson, D.C., & Kralj, B. (2001). Physician communication skills: Results of a survey of general/family practitioners in Newfoundland. *Medical Education Online*, *6*(1), 4521. https://doi.org/10.3402/meo.v6i.4521

Atkinson, P., & Silverman, D. (1997). Kundera's Immortality: The interview society and the invention of the self. *Qualitative Inquiry*, *3*(3), 304–325. https://doi.org/10.1177/107780049700300304

Aune, R.K., & Kikuchi, T. (1993). Effects of language intensity similarity on perceptions of credibility relational attributions, and persuasion. *Journal of Language and Social Psychology*, *12*(3), 224–238. https://doi.org/10.1177/0261927X93123004

Bakić-Mirić, N.M., & Bakić MN. (2008). Successful doctor-patient communication and rapport building as the key skills of medical practice. *Facta Universitatis, Medicine and Biology, 15*(2), 74–79.

Bakic-Miric, N.M., Butt, S., Kennedy, C., Bakic, N.M., Gaipov, D.E., Loncar-Vujnovic, M., & Davis, B. (2017). Communicating with patients from different cultures – Intercultural medical interview. *Srp Arh Celok Lek, 146*(1-2), 97-101. https://doi.org/10.2298/SARH170323149B

Bakic-Miric, N., Butt, S., Kennedy, C., Bakic, N., Gaipov, D., Loncar-Vujnovic, M., & Davis, B. (2018). Communicating with patients from different cultures: Intercultural medical interview. *Srpski arhiv za celokupno lekarstvo*, *146*(1-2), 97–101. https://doi.org/10.2298/SARH170323149B

Baldaszti, E. (2006). Stand der Forschung zur Migration in Osterreich [Current state of research on migration in Austria. A brief review]. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz*, *49*(9), 861–865. https://doi.org/10.1007/s00103-006-0019-3

Ball, J.W., Dains, J.E., Flynn, J.A., Soloman, B.S., & Stewart, R.W. (2014). Cultural competency. In Mosby Seidel (8th ed.), *Guide to physical examination* (pp.21-29). Amsterdam: Elsevier.

Ballinger, C. (2003). Navigating multiple research identities: Reflexivity in discourse analytic research. In B. Gough & L. Finlay (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp.66–77). Malden, MA: Blackwell Science.

Bardsley, M., & Storkey, M. (2000). Estimating the numbers of refugees in London. *Journal of Public Health Medicine*, *22*(3), 406–412. https://doi.org/10.1093/pubmed/22.3.406

Barry, C.A., Stevenson, F.A., Britten, N., Barber, N., & Bradley, C.P. (2001). Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor–patient communication in general practice. *Social Science & Medicine*, *53*(4), 487–505. https://doi.org/10.1016/S0277-9536(00)00351-8

Baumgartner, I. (2012). Handling interpretation and representation in multilingual research: A meta-study of pragmatic issues resulting from the use of multiple languages in a qualitative information systems research work. *The Qualitative Report*, *17*(42), 1–21. Retrieved from https://nsuworks.nova.edu/tqr/vol17/iss42/2

Beach, M.C., Keruly, J., & Moore, R.D. (2006). Is the quality of the patient-provider relationship associated with better adherence and health outcomes for patients with HIV? *Journal of General Internal Medicine*, *21*(6), 661–665. https://doi.org/10.1111/j.1525-1497.2006.00399.x

Beals, A.R., Spindler, G.D., & Spindler, L.S. (1967). *Culture in process*. New York, Montreal: Holt, Rinehart and Winston.

Beck, C.S. (2001). *Communicating for better health: A guide through the medical mazes*. Boston, MA: Allyn & Bacon.

Beck, R.S., Daughtridge, R., & Sloane, PD. (2002). Physician-patient communication in the primary care office: a systematic review. *J Am Board Fam Pract, 15*(1), 25–38. PMID:11841136

Bennett, J.K., Fuertes, J.N., Keitel, M., & Phillips, R. (2011). The role of patient attachment and working alliance on patient adherence, satisfaction, and health-related quality of life in lupus treatment. *Patient Education and Counseling*, *85*(1), 53–59. https://doi.org/10.1016/j.pec.2010.08.005

Bensing, J.M. (1991). Doctor-patient communication and the quality of care. *Social Science & Medicine*, *32*(11), 1301–1310. https://doi.org/10.1016/0277-9536(91)90047-G

Bensing, J.M., Tromp, F., van Dulmen, S., van den Brink-Muinen, A., Verheul, W., & Schellevis, F.G. (2006). Shifts in doctor-patient communication between 1986 and 2002: A study of videotaped general practice consultations with hypertension patients. *BMC Family Practice*, *7*, 62. https://doi.org/10.1186/1471-2296-7-62

Berger, C.R., & Calabrese, R.J. (1975). Some explorations in initial interaction and beyond: toward a developmental theory of interpersonal communication. *Human Communication Research*, *1*(2), 99–112. https://doi.org/10.1111/j.1468-2958.1975.tb00258.x

Bernard, H.R., & Ryan, G.W. (1998). Text analysis: Qualitative and quantitative methods. In H. R. Bernard (Ed.), *Handbook of methods in cultural anthropology* (pp.595–646). Lanham, MD: Altamira Press.

Berry, J.W. (1990). Psychology of acculturation. In J. J. Berman & G. Jahoda (Eds.), *Current theory and research in motivation: Vol. 37. Cross-cultural perspectives: Nebraska Symposium on Motivation, 1989* (pp.457–488). Lincoln: University of Nebraska Press.

Berry, J.W. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology*, *46*(1), 5–34. https://doi.org/10.1111/j.1464-0597.1997.tb01087.x

Berry-Cabán, C.S., & Crespo, H. (2008). Cultural competency as a skill for health care providers. *Hispanic Health Care International*, *6*(3), 115–121. https://doi.org/10.1891/1540-4153.6.3.115

Bertera, E.M., Bertera, R.L., & Shankar, S. (2003). Acculturation, socioeconomic factors and obesity smong immigrants from El Salvador living in the Washington, D.C. area. *Journal of Ethnic and Cultural Diversity in Social Work*, *12*(2), 43–59. https://doi.org/10.1300/J051v12n02_03

Betancourt, J.R., Green, A.R., Carrillo, J.E., & Park, E.R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs (Project Hope)*, *24*(2), 499–505. https://doi.org/10.1377/hlthaff.24.2.499

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research*, *10*(2), 141–163. https://doi.org/10.1177/004912418101000205

Binder-Fritz, C. (2010). Transkulturelle Kompetenz der Pflegepersonen im Krankenhaus als Fortbildungsziel. In W. Schnepp & I. Walter (Eds.), *Multikulturalität in Pflege und Gesellschaft: Zum 70. Geburtstag von Elisabeth Seidl* (pp.191–204). Wien: Böhlau.

Bird, C.M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry*, *11*(2), 226–248. https://doi.org/10.1177/1077800404273413

Bishop, F.L., & Holmes, M.M. (2013). Mixed methods in CAM Research: A systematic review of studies published in 2012. *Evidence-Based Complementary and Alternative Medicine: ECAM*, *2013*, Art. ID 187365. https://doi.org/10.1155/2013/187365

Blanck, P.D., Rosenthal, R., & Vanicelli, M. (1986). Nonverbal communication in the clinical context: The therapist's tone of voice. In P. D. Blanck, R. Buck, & R. Rosenthal (Eds.), *Nonverbal communication in the clinical context* (pp.99–143). University Park: Penn State University Press.

Bogdan, R.C., & Biklen, S.K. (1998). *Qualitative research for education: An introduction to theory and methods* (3rd ed.). Boston: Allyn & Bacon.

Bower, D.J., Reid, M., Barry, N., & Ibbotson, T. (2000). Aligning process and meaning: Innovating in complex healthcare delivery systems. *International Journal of Innovation Management*, *04*(03), 299–317. https://doi.org/10.1142/S1363919600000184

Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA, London: Sage.

Boyle, J.S. (1994). Styles of ethnography. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp.159–185). Thousand Oaks, CA: Sage.

Bradby, H. (2002). Translating culture and language: A research note on multilingual settings. *Sociology of Health & Illness*, *24*(6), 842–855. https://doi.org/10.1111/1467-9566.00321

Bradford, D. (2005). The biopsychosocial approach: Past, present, and future. *Psychiatric Services*, *56*(11), 1466-a-1467. https://doi.org/10.1176/appi.ps.56.11.1466-a

Braithwaite, D.O., & Baxter, L.A. (2008). Introduction: Meta-theory and theory in interpersonal communication research. In L. A. Baxter & D. Braithwaite (Eds.), *Engaging theories in interpersonal communication: Multiple perspectives* (pp.1–18). Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781483329529.n1

Brashers, D.E., Haas, S.M., & Neidig, J.L. (1999). The patient self-advocacy scale: Measuring patient involvement in health care decision-making interactions. *Health Communication*, *11*(2), 97–121. https://doi.org/10.1207/s15327027hc1102_1

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). What can 'thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-being*, *9*(1), 26152. https://doi.org/10.3402/qhw.v9.26152

Briggs, C.L. (1986). *Learning how to ask: A sociolinguistic appraisal of the role of the interview in social science research*. Cambridge, MA: Cambridge University Press.

Brody, H. (1994). 'My story is broken; can you help me fix it?' Medical ethics and the joint construction of narrative. *Literature and Medicine*, *13*(1), 79–92. https://doi.org/10.1353/lm.2011.0169

Bryman, A. (1988). *Quantity and quality in social research*. London: Routledge.

Bryman, A. (2012). *Social research methods* (4th ed.). Oxford: Oxford University Press.

Budman, C.L., Lipson, J.G., & Meleis, A.I. (1992). The cultural consultant in mental health care: The case of an Arab adolescent. *American Journal of Orthopsychiatry*, *62*(3), 359–370. https://doi.org/10.1037/h0079347

Burgess, D.J., Fu, S.S., & van Ryn, M. (2004). Why do providers contribute to disparities and what can be done about it? *Journal of General Internal Medicine*, *19*(11), 1154–1159. https://doi.org/10.1111/j.1525-1497.2004.30227.x

Burgoon, J.K., Bacue, AE. (2003). Nonverbal communication skills. In: JO. Green, BR. Burleson (Eds.), *Handbook of communication and social interaction skills* (pp.179-219). Mahwah: Erlbaum.

Burleson, B.R. (1992). Taking communication seriously. *Communication Monographs*, *59*(1), 79–86. https://doi.org/10.1080/03637759209376250

Butalid, L., Verhaak, P.F.M., Tromp, F., & Bensing, J.M. (2011). Changes in the quality of doctor-patient communication between 1982 and 2001: An observational study on hypertension care as perceived by patients and general practitioners. *BMJ Open*, *1*(1), e000203. https://doi.org/10.1136/bmjopen-2011-000203

Butler, A.E., Copnell, B., & Hall, H. (2018). The development of theoretical sampling in practice. *Collegian*, *25*(5), 561–566. https://doi.org/10.1016/j.colegn.2018.01.002

Butow, P.N., Goldstein, D., Bell, M.L., Sze, M., Aldridge, L.J., Abdo, S., Eisenbruch, M. (2011). Interpretation in consultations with immigrant patients with cancer: How accurate is it? *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology*, *29*(20), 2801–2807. https://doi.org/10.1200/JCO.2010.34.3335

Cameron, K.A., Silk, K.J., Afifi, W.A., & Theodori, J.B. (2000). *The doctor should meet: Patients' expectations and goals regarding physician-patient communication*. Paper presented at the National Communication Association Conference, Seattle, Washington. Seattle, WA.

Cape, J., & McCulloch, Y. (1999). Patients' reasons for not presenting emotional problems in general practice consultations. *The British Journal of General Practice*, *49*(448), 875–879.

Carroll, J., Epstein, R., Fiscella, K., Volpe, E., Diaz, K., & Omar, S. (2007). Knowledge and beliefs about health promotion and preventive health care among Somali women in the United States. *Health Care for Women International*, *28*(4), 360–380. https://doi.org/10.1080/07399330601179935

Cegala, D.J. (1997). A study of doctors' and patients' communication during a primary care consultation: Implications for communication training. *Journal of Health Communication*, *2*(3), 169–194. https://doi.org/10.1080/108107397127743

Cegala, D.J., Gade, C., Lenzmeier Broz, S., & McClure, L. (2002). *Physicians' and patients' perceptions of patients' communication competence in a primary care medical interview*. Paper presented at the National Communication Association Conference, New Orleans. New Orleans.

Cegala, D.J., McClure, L., Marinelli, T.M., & Post, D.M. (2000). The effects of communication skills training on patients' participation during medical interviews. *Patient Education and Counseling*, *41*(2), 209–222. https://doi.org/10.1016/S0738-3991(00)00093-8

Cegala, D.J., McGee, D.S., & McNeilis, K.S. (1996). Components of patients' and doctors' perceptions of communication competence during a primary care medical interview. *Health Communication*, *8*(1), 1–27. https://doi.org/10.1207/s15327027hc0801_1

Chang, M.K., & Harden, J.T. (2002). Meeting the challenge of the new millennium: Caring for culturally diverse patients. *Urologic Nursing*, *22*(6), 372-377.

Charles, C., Whelan, T., & Gafni, A. (1999). What do we mean by partnership in making decisions about treatment? *BMJ (Clinical Research Ed.)*, *319*(7212), 780–782. https://doi.org/10.1136/bmj.319.7212.780

Charmaz, K. (2001). Grounded Theory: Methodology and theory construction. In N. J. Smelser & P. B. Baltes (Eds.), *International encyclopedia of the social & behavioral sciences* (pp.6396–6399). Amsterdam: Elsevier.

Charon, R. (2001). The patient-physician relationship. Narrative medicine: A model for empathy, reflection, profession, and trust. *JAMA: The Journal of the American Medical Association*, *286*(15), 1897–1902. https://doi.org/10.1001/jama.286.15.1897

Chen, J., Ng, E., & Wilkins, R. (1996). The health of Canada's immigrants in 1994-95. *Health Reports*, *7*(4), 33-45.

Chenitz, W.C.C., & Swanson, J.M. (1993). *From practice to grounded theory: Qualitative research in nursing*. Reading, MA: Addison-Wesley.

Clandinin, D.J., & Connelly, F.M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco, CA: Jossey-Bass.

Claramita, M., Nugraheni, M.D.F., van Dalen, J., & van der Vleuten, C. (2013). Doctor-patient communication in Southeast Asia: A different culture? *Advances in Health Sciences Education: Theory and Practice*, *18*(1), 15–31. https://doi.org/10.1007/s10459-012-9352-5

Claramita, M., van Dalen, J., & Vleuten, C.P.M. van der (2011). Doctors in a Southeast Asian country communicate sub-optimally regardless of patients' educational background. *Patient Education and Counseling*, *85*(3), e169-74. https://doi.org/10.1016/j.pec.2011.02.002

Clark, H.H., & Bly, B. (1995). Pragmatics and discourse. In J. L. Miller & P. D. Eimas (Eds.), *Handbook of perception and cognition: Vol. 11. Speech, language, and communication* (pp.371–410). New York, NY: Academic Press.

Clark, R. A., & Delia, J.G. (1979). TOPOI and rhetorical competence. *Quarterly Journal of Speech*, *65*(2), 187–206. https://doi.org/10.1080/00335637909383470

Clarke, V., & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology*, *12*(3), 297–298. https://doi.org/10.1080/17439760.2016.1262613

Clever, S.L., Jin, L., Levinson, W., & Meltzer, D.O. (2008). Does doctor-patient communication affect patient satisfaction with hospital care? Results of an analysis with a novel instrumental variable. *Health Services Research*, *43*(5 Pt 1), 1505–1519. https://doi.org/10.1111/j.1475-6773.2008.00849.x

Cline, R.J.W. (2003). Everyday interpersonal communication and health. In T. L. Thompson (Ed.), *Handbook of health communication* (pp.285–313). Mahwah, NJ: Lawrence Erlbaum Associates.

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Thousand Oaks, CA: Sage.

Cole, S.A., & Bird, J. (2000). *The medical interview: The three-function approach* (2nd ed.). St. Louis, MO: Mosby.

Collins, H. (2018). Interculturality from above and below: navigating uneven discourses in a neoliberal university system. *Language and Intercultural Communication*, *18*(2), 167–183. https://doi.org/10.1080/14708477.2017.1354867

Comstock, L.M., Hooper, E.M., Goodwin, J.M., & Goodwin, J.S. (1982). Physician behaviors that correlate with patient satisfaction. *Journal of Medical Education*, *57*(2), 105–112.

Connelly, J.E. (2005). Narrative possibilities: Using mindfulness in clinical practice. *Perspectives in Biology and Medicine*, *48*(1), 84–94. https://doi.org/10.1353/pbm.2005.0006

Cooper-Patrick, L., Gallo, J.J., Gonzales, J.J., Vu, H.T., Powe, N.R., Nelson, C., & Ford, D.E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA: The Journal of the American Medical Association*, *282*(6), 583–589. https://doi.org/10.1001/jama.282.6.583

Cora-Bramble, D., & Williams, L. (2000). Explaining illness to Latinos. In B. B. Whaley (Ed.), *Explaining illness: Research, theory, and strategies* (pp.257–280). Mahwah, N.J: Lawrence Erlbaum Associates.

Corke, C.F., Stow, P.J., Green, D.T., Agar, J.W., & Henry, M.J. (2005). How doctors discuss major interventions with high risk patients: An observational study. *BMJ (Clinical Research Ed.)*, *330*(7484), 182. https://doi.org/10.1136/bmj.38293.435069.DE

Coulter, A. (2002). *The autonomous patient: Ending paternalism in medical care* (2nd Ed.). London: TSO.

Coupland, N., & Giles, H. (1988). Introduction the communicative contexts of accommodation. *Language & Communication*, *8*(3-4), 175–182. https://doi.org/10.1016/0271-5309(88)90015-8

Cousin, G. (2011). A literature review on how patient trust is affected by patient proximal percepts and by physician behavior. *Studies in Communication Sciences: journal of the Swiss Association of Communication and Media Research*, *11*(1), 157–171.

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.

Creswell, J.W., & Plano Clark, V.L. (2007). *Designing and conducting mixed methods research*. Los Angeles, CA: Sage.

Cutcliffe, J.R., & McKenna, H.P. (2004). Expert qualitative researchers and the use of audit trails. *Journal of Advanced Nursing*, *45*(2), 126-33; discussion 134-5.

Davidson, J. (2012). The journal project and the I in qualitative research: Three theoretical lenses on subjectivity and self. *The Qualitative Report*, *17*(32), 1–13. Retrieved from http://www.nova.edu/ssss/QR/QR17/davidson.pdf

Davis, T., Williams, M., Branch, W., & Green, K. (2000). Explaining illness to patients with limited literacy. In B. B. Whaley (Ed.), *Explaining illness: Research, theory, and strategies* (pp.123–146). Mahwah, N.J: Lawrence Erlbaum Associates.

Dearborn, J.L., Panzer, V.P., Burleson, J.A., Hornung, F.E., Waite, H., & Into, F.H. (2006). Effect of gender on communication of health information to older adults. *Journal of the American Geriatrics Society*, *54*(4), 637–641. https://doi.org/10.1111/j.1532-5415.2006.00665.x

De Maesschalck, S., Deveugele, M., Willems, S. (2011) Language, culture and emotions: Exploring ethnic minority patients' emotional expressions in primary healthcare consultations. *Patient Education and Counseling, 84*, 406-412.

Dempsey, P.A., & Dempsey, A.D. (1996). *Nursing research: Text and workbook* (4th ed.). Boston, London: Little Brown.

Denley, J., Rao, J.N., & Stewart, A. (2003). How do patients rate the quality of consultations in primary care? A patient enablement survey within a primary care trust in Sandwell. *Quality in Primary Care*, *11*(3), 181–187.

Denzin, N. (1989). *Interpretive biography*. Thousand Oaks, CA: Sage.

DePoy, E., & Gitlin, L.N. (2016). *Introduction to research: Understanding and applying multiple strategies* (5th ed.). St. Louis, MO: Elsevier.

Desjarlais-deKlerk, K., & Wallace, J.E. (2013). Instrumental and socioemotional communications in doctor-patient interactions in urban and rural clinics. *BMC Health Services Research*, *13*, 261. https://doi.org/10.1186/1472-6963-13-261

Devine, P.G., & Elliot, A.J. (1995). Are racial stereotypes really fading? The Princeton Trilogy revisited. *Personality and Social Psychology Bulletin*, *21*(11), 1139–1150. https://doi.org/10.1177/01461672952111002

Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. London: Routledge.

Dillon, J.T. (1990). *The practice of questioning*. London: Routledge.

Drew, P. (2014). Interpreted medical interaction: When doctors and patients do not speak the same language. *Patient Education and Counseling, 97*, 1-2.

Du Pré, A. (2002). Accomplishing the impossible: Talking about body and soul and mind during a medical visit. *Health Communication*, *14*(1), 1–21. https://doi.org/10.1207/S15327027HC1401_1

Dutta-Bergman, M.J. (2005). The relation between health-orientation, provider-patient communication, and satisfaction: An individual-difference approach. *Health Communication*, *18*(3), 291–303. https://doi.org/10.1207/s15327027hc1803_6

Emanuel, E.J., & Emanuel, L.L. (1992). Four models of the physician-patient relationship. *JAMA: The Journal of the American Medical Association*, *267*(16), 2221–2226. https://doi.org/10.1001/jama.1992.03480160079038

Emerson, R.M., Fretz, R.I., & Shaw, L.L. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.

Endacott, R., & Botti, M. (2007). Clinical research 3: Sample selection. *Accident and Emergency Nursing*, *15*(4), 234–238. https://doi.org/10.1016/j.aaen.2006.12.006

Epstein, R.M. (2007). Assessment in medical education. *The New England Journal of Medicine*, *356*(4), 387–396. https://doi.org/10.1056/NEJMra054784

Epstein, R.M., & Peters, E. (2009). Beyond information: Exploring patients' preferences. *JAMA: The Journal of the American Medical Association*, *302*(2), 195–197. https://doi.org/10.1001/jama.2009.984

Essers, G., van Dulmen, S., van Es, J., van Weel, C., van der Vleuten, C., & Kramer, A. (2013). Context factors in consultations of general practitioner trainees and their impact on communication assessment in the authentic setting. *Patient Education and Counseling*, *93*(3), 567–572. https://doi.org/10.1016/j.pec.2013.08.024

Etherington, K. (2007). Ethical research in reflexive relationships. *Qualitative Inquiry*, *13*(5), 599–616. https://doi.org/10.1177/1077800407301175

Evans, B.J., Stanley, R.O., & Burrows, G.D. (1992). Communication skills training and patients' satisfaction. *Health Communication*, *4*(2), 155–170. https://doi.org/10.1207/s15327027hc0402_5

Fairclough, N. (1995). *Critical discourse analysis: Papers in the critical study of language*. London: Longman.

Fallowfield, L. (2004). Doctors' communication of trust, care, and respect: Details of paper were incorrect. *BMJ (Clinical Research Ed.)*, *328*(7451), 1317. https://doi.org/10.1136/bmj.328.7451.1317-a

Field, P.A., & Morse, J.M. (1985). *Nursing research: The application of qualitative approaches*. London: Croom Helm.

Fielding, N.F., & Lee, R.M. (1998). *Computer analysis and qualitative research*. London: Sage.

Filep, B. (2009). Interview and translation strategies: coping with multilingual settings and data. *Social Geography Discussions*, *5*(1), 25–49. https://doi.org/10.5194/sgd-5-25-2009

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209–230. https://doi.org/10.1177/146879410200200205

Finlay, L. (2002). 'Outing' the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531–545. https://doi.org/10.1177/104973202129120052

Finlay, L. (2003). Through the looking glass. In L. Finlay & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp.105–119). Malden, MA: Blackwell Science.

Fisher, S. (1995). *Nursing wounds: Nurse practitioners, doctors, women patients and the negotiation of meaning*. New Brunswick, NJ: Rutgers University Press.

Flick, U., von Kardorff, E., & Steinke, I. (2007). Was ist Qualitative Forschung? Einleitung und Überblick. In U. Flick, E. von Kardorff, & I. Steinke (Eds.), *Qualitative Forschung: Ein Handbuch* (5th ed., pp.13–19). Reinbek bei Hamburg: Rowohlt.

Foley, L.A., & Kranz, P.L. (1981). Black stereotypes of other ethnic groups. *The Journal of Mind and Behavior*, *2*(4), 435–441.

Fontana, A., & Frey, J. (2000). The interview: From structured questions to negotiated text. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp.645–672). Thousand Oaks, CA: Sage.

Ford, S., Schofield, T., & Hope, T. (2006). Observing decision-making in the general practice consultation: Who makes which decisions? *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *9*(2), 130–137. https://doi.org/10.1111/j.1369-7625.2006.00382.x

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *The Australian and New Zealand Journal of Psychiatry*, *36*(6), 717–732. https://doi.org/10.1046/j.1440-1614.2002.01100.x

Fox, S.A., Heritage, J., Stockdale, S.E., Asch, S.M., Duan, N., & Reise, S.P. (2009). Cancer screening adherence: Does physician-patient communication matter? *Patient Education and Counseling*, *75*(2), 178–184. https://doi.org/10.1016/j.pec.2008.09.010

Frank, A.W. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago: University of Chicago Press.

Freeman, A.C., & Sweeney, K. (2001). Why general practitioners do not implement evidence: Qualitative study. *BMJ (Clinical Research Ed.)*, *323*(7321), 1100–1102. https://doi.org/10.1136/bmj.323.7321.1100

Frith, H., & Gleeson, K. (2011). Qualitative data collection: Asking the right questions. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp.55–68). Chichester: Wiley.

Früh, W. (2009). *Inhaltsanalyse: Theorie und Praxis* (6th ed.). Konstanz: UVK.

Gabbard-Alley, A.S. (2000). Explaining illness: An examination of message strategies and gender. In B. B. Whaley (Ed.), *Explaining illness: Research, theory, and strategies* (pp.147–170). Mahwah, N.J: Lawrence Erlbaum Associates.

Gao, G., Burke, N., Somkin, C.P., & Pasick, R. (2009). Considering culture in physician--patient communication during colorectal cancer screening. *Qualitative Health Research*, *19*(6), 778–789. https://doi.org/10.1177/1049732309335269

Gáspárik, A.I., Ábrám, Z., Ceana, D., Sebesi, S., Fărcaş, D., & Gáspárik, A.C. (2014). Shortages of doctor-patient communication. Teaching patients to communicate effectively. *Procedia - Social and Behavioral Sciences*, *142*, 376–379. https://doi.org/10.1016/j.sbspro.2014.07.693

Gau, S., Schlieben, K., & Ströbel, I. (2008). *Translation Paradoxes and Misunderstandings*. Zürich. Retrieved from Schedhalle website: http://archiv2009.shedhalle.ch/dt/programm/zeitung/08/inhalt_02/shedhalle_9_WEB.pdf

Geist, P. (1997). Negotiating cultural understanding in health care communication. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural communication: A reader* (8th ed., pp.340–348). Belmont, CA: Wadsworth.

Germain, C.P. (1986). Ethnography: The method. In P. L. Munhall & C. J. Oiler (Eds.), *Nursing research: A qualitative perspective* (pp.147–162). Norwalk: Appleton-Century-Crofts.

Germain, C.P. (1993). Qualitative approaches in nursing research. Ethnography: The method. *NLN Publications*. (19-2535), 237–268.

Gibbs, G. (2007). Analyzing qualitative data. In U. Flick (Ed.), *Designing qualitative research* (pp.100–108). London: Sage.

Gibson, W.J., & Brown, A. (2009). *Working with qualitative data*. London: Sage.

Gilbert, G.H., Rose, J.S., & Shelton, B.J. (2002). A prospective study of the validity of data on self-reported dental visits. *Community Dentistry and Oral Epidemiology*, *30*(5), 352–362.

Gilbert, L.S. (2002). Going the distance: 'Closeness' in qualitative data analysis software. *International Journal of Social Research Methodology*, *5*(3), 215–228. https://doi.org/10.1080/13645570210146276

Giles, H. (2008). Communication accommodation theory: 'When in Rome …" or not! In L. A. Baxter & D. Braithwaite (Eds.), *Engaging theories in interpersonal communication: Multiple perspectives* (pp.161–174). Thousand Oaks, CA: Sage.

Giorgi, A. (2007). *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press.

Goble, K.L., & Knight, S.M. (2012). *Integrative health coaching: A phenomenology of clients' discoveries*. Greenville, NC: East Carolina University.

Good, M.J.D., & Good, B.J. (2000). 'Fiction' and 'historicity' in doctors' stories: Social and narrative dimensions of learning medicine. In C. Mattingly & L. Garro (Eds.), *Narrative and the cultural construction of illness and healing* (pp.50–69). Berkeley, CA: University of California Press.

Gordon, H.S., Street, Jr R.L., Sharf, BF., Kelly, PA., & Souchek, J. (2006). Racial differences in trust and lung cancer patients' perceptions of physician communication. *J. Clinical Oncology, 24*, 904-909.

Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Greenfield, B.H., & Jensen, G.M. (2010). Understanding the lived experiences of patients: Application of a phenomenological approach to ethics. *Physical Therapy*, *90*(8), 1185–1197. https://doi.org/10.2522/ptj.20090348

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, *3*(1), 42–55. https://doi.org/10.1177/160940690400300104

Grol, R., de Maeseneer, J., Whitfield, M., & Mokkink, H. (1990). Disease-entered versus patient-centered attitudes: comparison of general practitioners in Belgium, Britain and the Netherlands. *Fam Pract, 7,* 100-103.

Grossman, E. (2010). *Why translation matters*. New Haven, London: Yale University Press.

Guadagnoli, E., & Ward, P. (1998). Patient participation in decision-making. *Social Science & Medicine*, *47*(3), 329–339.

Guba, E.G., & Lincoln, Y.S. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp.105–117). Thousand Oaks, CA: Sage.

Guba, E.G., & Lincoln, Y.S. (1994). *Fourth generation evaluation*. Newbury Park, CA: Sage.

Gudykunst, W.B. (1998). Applying anxiety\uncertainty management (AUM) theory to intercultural adjustment training. *International Journal of Intercultural Relations*, *22*(2), 227–250. https://doi.org/10.1016/S0147-1767(98)00005-4

Gudykunst, W. B., & Kim, Y. Y. (2003). *Communicating with strangers*. New York, NY: McGraw Hill.

Guest, G., MacQueen, K.M., & Namey, E.E. (2012). *Applied thematic analysis*. Thousand Oaks, CA: Sage.

Gwyn, R. (2002). *Communicating health and illness.* Thousand Oaks: SAGE Publications, 6–92, 120–66.

Hall, J.A. (1998). How big are nonverbal sex differences? The case of smiling and sensitivity to nonverbal cues. In D. J. Canary & K. Dindia (Eds.), *Sex differences and similarities in communication: Critical essays and empirical investigations of sex and gender in interaction* (pp.155–177). Mahwah, NJ: Lawrence Erlbaum Associates.

Hall, J.A., & Dornan, M.C. (1988). Meta-analysis of satisfaction with medical care: Description of research domain and analysis of overall satisfaction levels. *Social Science & Medicine*, *27*(6), 637–644.

Hall, J.A., Roter, D.L., & Katz, N.R. (1988). Meta-analysis of correlates of provider behavior in medical encounters. *Medical Care*, *26*(7), 657–675.

Halperin, E.C. (2010). Preserving the humanities in medical education. *Medical Teacher*, *32*(1), 76–79. https://doi.org/10.3109/01421590903390585

Hamberg, K. (2008). Gender bias in medicine. *Women's Health*, *4*(3), 237–243. https://doi.org/10.2217/17455057.4.3.237

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). London: Routledge.

Harmsen, H.A.M., Meeuwesen, L., van Wieringen, J.C.M., Bernsen, R., & Bruijnzeels, M. (2003). When cultures meet in general practice: Intercultural differences between GPs and parents of child patients. *Patient Education and Counseling*, *51*(2), 99–106.

Harmsen, J.A.M., Bernsen, R.M.D., Bruijnzeels, M.A., & Meeuwesen, L. (2008). Patients' evaluation of quality of care in general practice: What are the cultural and linguistic barriers? *Patient Education and Counseling*, *72*(1), 155–162. https://doi.org/10.1016/j.pec.2008.03.018

Harris, M. (1976). History and significance of the emic/etic distinction. *Annual Review of Anthropology*, *5*, 329–350.

Haugen, E. (1987). *Blessings of Babel: Bilingualism and language planning: problems and pleasures*. Berlin, New York: De Gruyter Mouton.

Have, P. ten. (2004). *Understanding qualitative research and ethnomethodology*. London: Sage.

Heidegger, M. (2008). The question concerning technology. In D. F. Krell (Ed.), *Martin Heidegger: Basic writings* (pp.311–341). London: Harper Perennial.

Helman, C.G. (2007). *Culture, health and illness* (5th ed.). London: Hodder Arnold.

Hendrick, C., & Hendrick, S.S. (2000). *Close Relationships: A Sourcebook*. Thousand Oaks, CA: Sage.

Hepburn, A., & Potter, J. (2004). Discourse analytic practice. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative Research Practice* (pp.180–196). London: Sage.

Hillen, MA., de Haes, H.C.J.M., Verdam, M.G.E., Smets, E.M.A. (2018) Trust and Perceptions of Physicians' Nonverbal Behavior Among Women with Immigrant Backgrounds. *J. Immigrant Minority Health, 20*, 963-971. https://doi.org/10.1007/s10903-017-0580-x

Hoff, T.J., & Witt, L.C. (2000). Exploring the use of qualitative methods in published health services and management research. *Medical Care Research and Review*, *57*(2), 139–160. https://doi.org/10.1177/107755870005700201

Hofstede, G.H. (1991). *Cultures and organizations. Software of the mind: Intercultural cooperation and its importance for survival*. New York, NY: McGraw-Hill.

Hofstede, G.H. (2001). *Culture's consequences: International differences in work-related values*. Beverly Hills, CA: Sage.

Holliday, A. (1999). Culture as constraint or resource: Essentialist versus non-essentialist views. *IATELF Language and Cultural Studies SIG Newsletter*. (18), 38–40.

Holliday, A. (1999). Small cultures. *Applied Linguistics*, *20*(2), 237–264. https://doi.org/10.1093/applin/20.2.237

Holliday, A. (2011). *Intercultural communication and ideology*. Los Angeles: Sage.

Holliday, A. (2013). *Understanding intercultural communication: Negotiating a grammar of culture*. London: Routledge.

Holliday, A., Kullman, J., & Hyde, M. (2004). *Intercultural communication: An advanced resource book for students*. London: Routledge.

Holloway, I., & Freshwater, H. (2009). *Narrative Research in Nursing*. Chichester: Wiley.

Holstein, J.A., & Gubrium, J.F. (1997). Narrative practice and the active interview: Active interviewing. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (pp.113–129). London: Sage.

Holsti, O.R. (1969). *Content analysis for the social sciences and the humanities*. Reading, MA: Addison-Wesley.

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher*, *20*(4), 12–17.

Hovey, J.D., & Magaña, C. (2000). Acculturative stress, anxiety, and depression among Mexican immigrant farmworkers in the Midwest United States. *Journal of Immigrant Health*, *2*(3), 119–131. https://doi.org/10.1023/A:1009556802759

Hughes, A.K. (2013). Mid-to-late-life women and sexual health: communication with healthcare providers. *Fam Med, 45*(4), 252–256. PMID:23553088

Hughes, P.C., & Baldwin, J.R. (2002). Communication and stereotypical impressions. *Howard Journal of Communications*, *13*(2), 113–128. https://doi.org/10.1080/10646170290089917

Hultsjö, S., Berterö, C., Arvidsson, H., & Hjelm, K. (2011). Core components in the care of immigrants with psychoses: A Delphi survey of patients, families, and health-care staff. *International Journal of Mental Health Nursing*, *20*(3), 174–184. https://doi.org/10.1111/j.1447-0349.2010.00720.x

Hultsjö, S., & Hjelm, K. (2005). Immigrants in emergency care: Swedish health care staff's experiences. *International Nursing Review*, *52*(4), 276–285. https://doi.org/10.1111/j.1466-7657.2005.00418.x

Hunt, L.M., & de Voogd, K.B. (2005). Clinical myths of the cultural 'other': Implications for Latino patient care. *Academic Medicine: Journal of the Association of American Medical Colleges*, *80*(10), 918–924.

Hunter, K.M. (1991). *Doctors' stories: The narrative structure of medical knowledge*. Princeton, NJ: Princeton University Press.

Iacono, T., & Johnson, H. (2004). Patients with disabilities and complex communication needs. The GP consultation. *Australian Family Physician*, *33*(8), 585–589.

Iannotta, J.G. (2002). Determinants of Health. In J. G. Iannotta (Ed.), *Emerging Issues in Hispanic Health: Summary of a Workshop* (pp.15–21). Washington DC: The National Academies Press.

IOM (2017). *Migration and migrants: A global overview (Chapter 2)*. World Migration Report 2018. Geneva. Retrieved from International Organization for Migration website: https://www.iom.int/wmr/chapter-2

Jackson, S.D. (2012). *African American acculturation and its relationship to subjective well-being*. Ann Arbour, MI: Proquest, UMI Dissertation Publishing.

Jain, P. (2014). Intergroup, interpersonal, and intercultural nature of patient–provider communication: A comparison of IMG and USMG physicians. *The Communication Review*, *17*(1), 27–44. https://doi.org/10.1080/10714421.2014.872498

Jansen, J., van Weert, J., van der Meulen, N., van Dulmen, S., Heeren, T., & Bensing, J.M. (2008). Recall in older cancer patients: Measuring memory for medical information. *The Gerontologist*, *48*(2), 149–157. https://doi.org/10.1093/geront/48.2.149

Jirwe, M., Gerrish, K., & Emami, A. (2010). Student nurses' experiences of communication in cross-cultural care encounters. *Scandinavian Journal of Caring Sciences*, *24*(3), 436–444. https://doi.org/10.1111/j.1471-6712.2009.00733.x

Johnson, R.L., Saha, S., Arbelaez, J.J., Beach, MC., & Cooper, LA. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine, 19*, 101-110.

Johnson, K. (2011). *Motivational interviewing with patient education to promote a safe sleep environment for Lakota infants*. Minneapolis, MN: Augsburg College.

Jones, E., Gallois, C., Callan, V., & Barker, M. (1999). Strategies of accommodation. *Journal of Language and Social Psychology*, *18*(2), 123–151. https://doi.org/10.1177/0261927X99018002001

Jootun, D., McGhee, G., & Marland, G.R. (2009). Reflexivity: Promoting rigour in qualitative research. *Nursing Standard*, *23*(23), 42–46. https://doi.org/10.7748/ns2009.02.23.23.42.c6800

Kagawa-Singer, M., & Blackhall, L.J. (2001). Negotiating cross-cultural issues at the end of life: 'you got to go where he lives'. *JAMA: The Journal of the American Medical Association*, *286*(23), 2993–3001. https://doi.org/10.1001/jama.286.23.2993

Kale, E., Finset, A., Eikeland, H.□L., & Gulbrandsen, P. (2011). Emotional cues and concerns in hospital encounters with non-Western immigrants as compared with Norwegians: An exploratory study. *Patient Education and Counseling*, *84*(3), 325–331. https://doi.org/10.1016/j.pec.2011.05.009

Kale, E., Skjeldestad, K., & Finset, A. (2013). Emotional communication in medical consultations with native and non-native patients applying two different methodological approaches. *Patient Education and Counseling*, *92*(3), 366–374. https://doi.org/10.1016/j.pec.2013.06.028

Karliner, L.S., Jacobs, E.A., Chen, A.H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research*, *42*(2), 727–754. https://doi.org/10.1111/j.1475-6773.2006.00629.x

Karnieli-Miller, O., Werner, P., Neufeld-Kroszynski, G., & Eidelman, S. (2012). Are you talking to me?! An exploration of the triadic physician-patient-companion communication within memory clinics encounters. *Patient Education and Counseling*, *88*(3), 381–390. https://doi.org/10.1016/j.pec.2012.06.014

Katz, M.L., Broder-Oldach, B., Fisher, J.L., King, J., Eubanks, K., Fleming, K., & Paskett, E.D. (2012). Patient-provider discussions about colorectal cancer screening: Who initiates elements of informed decision making? *Journal of General Internal Medicine*, *27*(9), 1135–1141. https://doi.org/10.1007/s11606-012-2045-1

Kelly, G.A. (1955). *The psychology of personal constructs* (Vol. 1). New York, NY: Norton.

Kim, M.S. (1995). Toward a theory of conversational constraints: Focusing on individual level dimensions of culture. In R. Wiseman (Ed.), *Intercultural communication theory* (pp.148–169). Thousand Oaks, CA: Sage.

Kim, Y.Y. (1988). *Communication and cross-cultural adaptation: An integrative theory*. Clevedon: Multilingual Matters.

Kim, Y.Y. (1995). Cross-cultural adaptation: An integrative theory. In R. Wiseman (Ed.), *Intercultural communication theory* (pp.170–193). Thousand Oaks, CA: Sage.

Kim, Y.Y. (2001). *Becoming intercultural: An integrative theory of communication and cross-cultural adaptation*. Thousand Oaks, CA: Sage.

Kim, Y.Y. (2005). Adapting to a new culture: An integrative communication theory. In W. B. Gudykunst (Ed.), *Theorizing about intercultural communication* (pp.375–400). Thousand Oaks, CA: Sage.

Kirk, J., & Miller, M. (1986). *Reliability and validity in qualitative research*. Thousand Oaks, CA: Sage.

Kissane, D., Bultz, B., & Butow, P. (2010). *Handbook of Communication in Oncology and Palliative Care*. Oxford: Oxford University Press.

Kleinman, A. (1981). The meaning context of illness and care: Reflections on a central theme in the anthropology of medicine. In R. D. Whitley, E. Mendelsohn, & Y. Elkana (Eds.), *Sciences and Cultures: Anthropological and historical studies of the sciences* (pp.161–176). Dordrecht: Springer.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York, NY: Basic Books.

Knapp, M.L., & Hall, J.A. (2010). *Nonverbal communication in human interaction* (7th ed.). Boston, MA: Wadsworth CENGAGE Learning.

Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, *53*(1), 91-100. https://doi.org/10.1111/j.1365-2648.2006.03681.x

Kokanovic, R., Manderson, L. (2007). Exploring doctor-patient communication in immigrant Australians with type2 diabetes: a qualitative study. *J Gen Intern Med, 22*(4), 459–63. https://doi.org/10.1007/s11606-0070143-2PMID:17372793

Kreps, G.L., & Kunimoto, E.N. (1994). *Effective communication in multicultural health care settings* (Vol. 3). Thousand Oaks, CA: Sage.

Krippendorff, K. (2004). *Content analysis: An introduction to its methodology*. Los Angeles: Sage.

Kuo, W.H., & Tsai, Y.□M. (1986). Social networking, Hardiness and immigrant's mental health. *Journal of Health and Social Behavior*, *27*(2), 133. https://doi.org/10.2307/2136312

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage.

Kvale, S. (2007). *Doing interviews*. London: Sage.

Lakatos, P.L. (2009). Prevalence, predictors, and clinical consequences of medical adherence in IBD: How to improve it? *World Journal of Gastroenterology*, *15*(34), 4234–4239. https://doi.org/10.3748/wjg.15.4234

Lambert, B.L., Street, R.L., Cegala, D.J., Smith, D.H., Kurtz, S., & Schofield, T. (1997). Provider-patient communication, patient-centered care, and the mangle of practice. *Health communication*, *9*(1), 27–43. https://doi.org/10.1207/s15327027hc0901_3

Landmark, A.M.D., Svennevig, J., Gerwing, J., Gulbrandsen, P. (2017). Patient Involvement and language barriers: Problems of agreement or understanding? *Patient Education and Counseling, 100*, 1992-1102.

Langewitz, W. (2007). Beyond content analysis and non-verbal behaviour - what about atmosphere? A phenomenological approach. *Patient Education and Counseling*, *67*(3), 319–323. https://doi.org/10.1016/j.pec.2007.04.009

Lapadat, J.C., & Lindsay, A.C. (1999). Transcription in research and practice: From standardization of technique to interpretive positionings. *Qualitative Inquiry*, *5*(1), 64–86. https://doi.org/10.1177/107780049900500104

LaVeist, T.A., & Carroll, T. (2002). Race of physician and satisfaction with care among African-American patients. *Journal of the National Medical Association*, *94*(11), 937–943.

Lee, C. (2009). "Race" and "ethnicity" in biomedical research: How do scientists construct and explain differences in health? *Soc Sci Med, 68*, 1183–1190. https://doi.org/10.1016/j.socscimed.2008.12.036PMID: 19185964

Leininger, M.M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In M. M. Leininger (Ed.), *Qualitative research methods in nursing* (pp.33–71). Philadelphia: Saunders.

Levinson, W., Gorawara-Bhat, R., Dueck, R., Egener, B., Kao, A., Kerr, C., Kemp-White, M. (1999). Resolving disagreements in the patient-physician relationship: Tools for improving communication in managed care. *JAMA: The Journal of the American Medical Association*, *282*(15), 1477–1483. https://doi.org/10.1001/jama.282.15.1477

Lewins, A., Taylor, C., & Gibbs, G. (2005). *What is qualitative data analysis?* Huddersfield: School of Human and Health Sciences, University of Huddersfield.

Li, H.Z. (2016). Cooperative and intrusive interruptions in inter- and intracultural dyadic discourse. *Journal of Language and Social Psychology*, *20*(3), 259–284. https://doi.org/10.1177/0261927X01020003001

Lindlof, T.R. (1995). *Qualitative communication research methods*. Thousand Oaks, CA: Sage.

Linzer, M., & Harwood, E. (2018). Gendered expectations: Do they contribute to high burnout among female physicians? *Journal of General Internal Medicine*, *33*(6), 963–965. https://doi.org/10.1007/s11606-018-4330-0

Littlejohn, S.W., & Foss, K.A. (2005). *Theories of human communication* (8th ed.). Southbank: Thomson Wadsworth.

Logan, S., Steel, Z., & Hunt, C. (2016). Intercultural willingness to communicate within health services: Investigating anxiety, uncertainty, ethnocentrism and help seeking behaviour. *International Journal of Intercultural Relations*, *54*, 77–86. https://doi.org/10.1016/j.ijintrel.2016.07.007

Loosveldt, G., & Beullens, K. (2013). The impact of respondents and interviewers on interview speed in face-to-face interviews. *Social science research*, *42*(6), 1422–1430. https://doi.org/10.1016/j.ssresearch.2013.06.005

Lustig, M.W., & Koester, J. (1999). *Intercultural competence: Interpersonal communication across cultures* (3rd ed.). Harlow: Longman.

Mack, N. (2005). *Qualitative research methods: A data collector's field guide*. North Carolina: Family Health International.

Macnaughton, J. (2009). The dangerous practice of empathy. *Lancet*, *373*(9679), 1940–1941. https://doi.org/10.1016/s0140-6736(09)61055-2

MacQueen, K.M., & Milstein, B. (1999). A systems approach to qualitative data management and analysis. *Field Methods*, *11*(1), 27–39. https://doi.org/10.1177/1525822X9901100103

Maggs-Rapport, F. (2001). 'Best research practice': In pursuit of methodological rigour. *Journal of Advanced Nursing*, *35*(3), 373–383. https://doi.org/10.1046/j.1365-2648.2001.01853.x

Maguire, P., & Pitceathly, C. (2002). Key communication skills and how to acquire them. *BMJ (Clinical Research Ed.)*, *325*(7366), 697–700. https://doi.org/10.1136/bmj.325.7366.697

Makoul, G., & Clayman, M.L. (2006). An integrative model of shared decision making in medical encounters. *Patient Education and Counseling*, *60*(3), 301–312. https://doi.org/10.1016/j.pec.2005.06.010

Maltby, J. (2013). *Research methods for nursing and healthcare*. Milton Park, Abingdon, Oxon: Routledge.

Manderson, L., Bennett, E., & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: Age, class, and gender. *Qualitative Health Research*, *16*(10), 1317–1334. https://doi.org/10.1177/1049732306294512

Mantwill, S., & Schulz, P.J. (2017). Does acculturation narrow the health literacy gap between immigrants and non-immigrants-An explorative study. *Patient Education and Counseling*, *100*(4), 760–767. https://doi.org/10.1016/j.pec.2016.10.021

Manusov, V., Winchatz, M.R., & Manning, L.M. (1997). Acting out our minds: Incorporating behavior into models of stereotype□based expectancies for cross□cultural interactions. *Communication Monographs*, *64*(2), 119–139. https://doi.org/10.1080/03637759709376410

Marks, L., & Worboys, M. (2002). *Migrants, minorities, and health: Historical and contemporary studies*. London: Taylor & Francis. https://doi.org/10.4324/9780203208175

Marshall, C. (2016). *Designing qualitative research* (6th ed.). Los Angeles: Sage.

Martin, J.N., Nakayama, T.K., & Carbaugh, D. (2012). The history and development of the study of intercultural communication and applied linguistics. In J. Jackson (Ed.), *The Routledge handbook of language and intercultural communication* (pp.17–36). London: Routledge. https://doi.org/10.4324/9780203805640.ch1

Mast, M.S. (2007). On the importance of nonverbal communication in the physician-patient interaction. *Patient Education and Counseling*, *67*(3), 315–318. https://doi.org/10.1016/j.pec.2007.03.005

Matheson, J.L. (2007). The voice transcription technique: Use of voice recognition software to transcribe digital interview data in qualitative research. *The Qualitative Report*, *12*(4), 547–560. Retrieved from https://nsuworks.nova.edu/tqr/vol12/iss4/1

Matthias, MS., Bair, M.J., Nyland, K.A., Huffman, MA., Stubbs, D.L., Damush, T.M, et al. (2010). Self-management support and communication from nurse care managers compared with primary care physicians: a focus group study of patients with chronic musculoskeletal pain. *Pain Manag Nurs, 11*(1), 26–34. https://doi.org/10.1016/j.pmn.2008.12.003PMID:20207325

Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. Chicago, IL: Cambridge University Press.

Mauch, J.E., & Birch, J.W. (1989). *Guide to the successful thesis and dissertation: Conception to publication: A handbook for students and faculty*. New York, NY: Dekker.

Mayring, P. (2007). Qualitative Inhaltsanalyse. In U. Flick, E. von Kardorff, & I. Steinke (Eds.), *Qualitative Forschung: Ein Handbuch* (5th ed., pp.468–474). Reinbek bei Hamburg: Rowohlt.

McKay, M., Davis, M., & Fanning, P. (1983). *Messages. The communication book*. Oakland, CA: New Harbinger Publications.

McKinstry, B. (2008). Are there too many female medical graduates? Yes. *BMJ (Clinical Research Ed.)*, *336*(7647), 748. https://doi.org/10.1136/bmj.39505.491065.94

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine*, *51*(7), 1087–1110.

Meeuwesen, L., Harmsen, J.A.M., Bernsen, R.M.D., & Bruijnzeels, M.A. (2006). Do Dutch doctors communicate differently with immigrant patients than with Dutch patients? *Social Science & Medicine*, *63*(9), 2407–2417. https://doi.org/10.1016/j.socscimed.2006.06.005

Meeuwis, M., & Sarangi, S. (1994). Intercultural or not? Beyond celebration of cultural differences in miscommunication analysis. *Pragmatics*, *4*(3), 409–427.

Mehan, H. (1979). *Learning lessons: Social organization in the classroom*. Cambridge, MA: Harvard University Press.

Mercer, SW., Cawston, PG., & Bikker, AP. (2007). Quality in general practice consultations; a qualitative study of the views of patients living in an area of high socio-economic deprivation in Scotland. *BMC Fam Pract, 8*, 1–9.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology*, *11*(5), 799–808. https://doi.org/10.1177/1359105306066643

Miles, M., & Huberman, M. (1984). *Qualitative data analysis*. Beverly Hills: Sage.

Miles, M.B., Huberman, A.M., & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage.

Miller, G., & Holstein, J.A. (1993). *Constructionist controversies: Issues in social problems theory*. New York: Aldine de Gruyter.

Miller, J., & Glassner, B. (2009). The 'inside" and the 'outside": Finding realities in interviews. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (2nd ed., pp.125–140). Los Angeles, CA: Sage.

Miller, J. (1983). *Many voices: Bilingualism, culture and education*. London: Routledge & Kegan Paul.

Miller, T., & Boulton, M. (2007). Changing constructions of informed consent: Qualitative research and complex social worlds. *Social Science & Medicine*, *65*(11), 2199–2211. https://doi.org/10.1016/j.socscimed.2007.08.009

Ming-Cheng, M.L. (2010). Cultural brokerage: Creating linkages between voices of lifeworld and medicine in cross-cultural clinical settings. *Health*, *14*(5), 484–504. https://doi.org/10.1177/1363459309360795

Mishler, E.G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.

Mishler, E.G. (1986). *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press.

Mitchell, A., & Cormack, M.A. (1998). *The therapeutic relationship in complementary health care*. Edinburgh: Livingstone.

Moffat, M., Cleland, J., van der Molen, T., & Price, D. (2006). Sub-optimal patient and physician communication in primary care consultations: its relation to severe and difficult asthma. *Prim Care Respir J, 15*(3), 159–65. https://doi.org/10.1016/j.pcrj.2006.02.006PMID:16757396

Morse, J.M., & Field, P.A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Morse, J.M., & Field, P.A. (1996). *Nursing research: The application of qualitative approaches* (2nd ed.). Cheltenham: Stanley Thornes.

Morse, J.M., & Richards, L. (2002). *Readme first for a user's guide to qualitative methods*. Thousand Oaks, CA: Sage.

Mouzon, D. (2008). *A critical examination of race, ethnicity and cultural competency in health care*. Retrieved from http://citation.allacademic.com/meta/p_mla_apa_research_citation/1/8/4/8/6/pages184869/p184869-1.php

Murphy, E., Dingwall, R., Greatbatch, D., Parker, S., & Watson, P. (1998). Qualitative research methods in health technology assessment: A review of the literature. *Health Technology Assessment*, *2*(16), iii-ix, 1-274.

Murray-García, J.L., Selby, J.V., Schmittdiel, J., Grumbach, K., & Quesenberry, C.P. (2000). Racial and ethnic differences in a patient survey: Patients' values, ratings, and reports regarding physician primary care performance in a large health maintenance organization. *Medical Care*, *38*(3), 300–310.

Nathan, G. (2015). A non-essentialist model of culture: Implications of identity, agency and structure within multinational/multicultural organizations. *International Journal of Cross Cultural Management*, *15*(1), 101–124. https://doi.org/10.1177/1470595815572171

Navas, M., Rojas, A.J., García, M., & Pumares, P. (2007). Acculturation strategies and attitudes according to the Relative Acculturation Extended Model (RAEM): The perspectives of natives versus immigrants. *International Journal of Intercultural Relations*, *31*(1), 67–86. https://doi.org/10.1016/j.ijintrel.2006.08.002

Neuendorf, K.A. (2002). *The content analysis guidebook*. Thousand Oaks, CA: Sage.

Neuliep, JW. (2012). *Intercultural Communication: A contextual approach* (5th ed.). Thousand Oaks, CA: Sage.

Newbold, K.B., & Willinsky, J. (2009). Providing family planning and reproductive healthcare to Canadian immigrants: Perceptions of healthcare providers. *Culture, Health & Sexuality*, *11*(4), 369–382. https://doi.org/10.1080/13691050802710642

Nkulu Kalengayi, F.K., Hurtig, A.K., Ahlm, C., & Ahlberg, B.M. (2012). 'It is a challenge to do it the right way': An interpretive description of caregivers' experiences in caring for migrant patients in Northern Sweden. *BMC Health Services Research*, *12*, 433. https://doi.org/10.1186/1472-6963-12-433

Noro, I., Roter, D.L., Kurosawa, S., Miura, Y., & Ishizaki, M. (2018). The impact of gender on medical visit communication and patient satisfaction within the Japanese primary care context. *Patient Education and Counseling*, *101*(2), 227–232. https://doi.org/10.1016/j.pec.2017.08.001

Nussbaum, J.F., Pecchioni, L., Grant, J.A., & Folwell, A. (2000). Explaining illness to older adults. In B. B. Whaley (Ed.), *Explaining illness: Research, theory, and strategies* (pp.171–194). Mahwah, N.J: Lawrence Erlbaum Associates.

O'Connell, D.C., & Kowal, S. (1995). Basic principles of transcription. In J. A. Smith, R. Harré, & L. van Langenhove (Eds.), *Rethinking methods in psychology* (pp.93–105). London: Sage.

OECD Statistics (2017). Health expenditure and financing. Retrieved from https://stats.oecd.org/

Ong, L.M.L., de Haes, J.C.J.M., Hoos, A.M., & Lammes, F.B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine*, *40*(7), 903–918. https://doi.org/10.1016/0277-9536(94)00155-M

Opler, M.E. (1945). Themes as dynamic forces in culture. *American Journal of Sociology*, *51*(3), 198–206. https://doi.org/10.1086/219787

Paez, K.A., Allen, J.K., Carson, K.A., & Cooper, L.A. (2008). Provider and clinic cultural competence in a primary care setting. *Social Science & Medicine*, *66*(5), 1204–1216. https://doi.org/10.1016/j.socscimed.2007.11.027

Park, J., Woodrow, S.I., Reznick, R.K., Beales, J., & MacRae, H.M. (2007). Patient care is a collective responsibility: Perceptions of professional responsibility in surgery. *Surgery*, *142*(1), 111–118. https://doi.org/10.1016/j.surg.2007.02.008

Patternotte, E., Scheele, F., Seeleman, C.M., Bank, L., Scherpbierf, A.J.J.A., & van Dulmen, S. (2016). Intercultural doctor-patient communication in daily outpatient care: relevant communication skills. *Perspective Medical Education, 5*, 268-275. https://doi.org/ 10.1007/s40037-016-0288-y https://doi.org/

Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, Calif.: Sage.

Patton, M.Q. (2009). *Qualitative research & evaluation methods* (3rd ed.). London: Sage.

Pecchioni, L.L., & Nussbaum, J.F. (2000). The influence of autonomy and paternalism on communicative behaviors in mother-daughter relationships prior to dependency. *Health Communication*, *12*(4), 317–338. https://doi.org/10.1207/S15327027HC1204_1

Peintinger, M. (2011). *Interkulturell kompetent: Ein Handbuch für Ärztinnen und Ärzte*. Wien: Facultas.

Penman, R. (1994). Facework in communication: Conceptual and moral challenges. In S. Ting-Toomey (Ed.), *The challenge of facework: Cross cultural and interpersonal issues* (pp.15–46). Albany: SUNY Press.

Penn, N.E., Kar, S., Kramer, J., Skinner, J., & Zambrana, R.E. (1995). Ethnic minorities, health care systems, and behavior. *Health Psychology*, *14*(7), 641–646.

Pérez-STable, E.J., Nápoles-Springer, A., & Miramontes, J.M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Medical Care*, *35*(12), 1212–1219.

Perloff, R.M., Bonder, B., Ray, G.B., Ray, E.B., & Siminoff, L.A. (2006). Doctor-patient communication, cultural competence, and minority health. *American Behavioral Scientist*, *49*(6), 835–852. https://doi.org/10.1177/0002764205283804

Peshkin, A. (1988). In search of subjectivity. One's own. *Educational Researcher*, *17*(7), 17. https://doi.org/10.2307/1174381

Pinzon-Perez, H., Perez, M., Torres, V., & Krenz, V. (2005). A qualitative study about cervical cancer screening among Latinas living in a rural area of California: Lessons for health educators. *American Journal of Health Education*, *36*(4), 228–236. https://doi.org/10.1080/19325037.2005.10608189

Pocovnicu, A., & Vasilache, S. (2012). An interview-based assessment of the influence of ethnocentrism in business. *Revista De Management Comparat International, 13*(3), 478–492.

Poirier, M.K., Clark, M.M., Cerhan, J.H., Pruthi, S., Geda, Y.E., & Dale, L.C. (2004). Teaching motivational interviewing to first-year medical students to improve counseling skills in health behavior change. *Mayo Clinic Proceedings*, *79*(3), 327–331. https://doi.org/10.4065/79.3.327

Poland, B.D. (1995). Transcription quality as an aspect of rigor in qualitative research. *Qualitative Inquiry*, *1*(3), 290–310. https://doi.org/10.1177/107780049500100302

Poland, B.D., & Pederson, A. (2016). Reading between the lines: Interpreting silences in qualitative research. *Qualitative Inquiry*, *4*(2), 293–312. https://doi.org/10.1177/107780049800400209

Polit, D.F., & Hungler, B.P. (1997). *Essentials of nursing research: Methods, appraisal and utilization* (4th ed.). Philadelphia, New York: Lippincott.

Ponterotto, J.G. (2006). Brief Note on the Origins, Evolution, and Meaning of the Qualitative Research Concept 'Thick Description'. *The Qualitative Report*, *11*(3), 538–549.

Potocky-Tripodi, M. (2002). *Best practices for social work with refugees and immigrants*. New York, NY: Columbia University Press.

Priebe, S., Sandhu, S., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., Bogic, M. (2011). Good practice in health care for migrants: Views and experiences of care professionals in 16 European countries. *BMC Public Health*, *11*, 187. https://doi.org/10.1186/1471-2458-11-187

Probst, B. (2015). The eye regards itself: Benefits and challenges of reflexivity in qualitative social work research. *Social Work Research*, *39*(1), 37–48. https://doi.org/10.1093/swr/svu028

Procter, S., & Allan, T. (2006). Sampling. In K. Gerrish & A. Lacey (Eds.), *The research process in nursing* (5th ed., pp.173–188). Oxford: Blackwell.

Rao, M.S. (2002). *Look after yourself-- no one else will. How to bypass the medical profession and stay healthy: A wholistic [sic] medical practitioner wrests control from the doctor and puts us in charge of health, illness and treatment*. London: Blackie & Co.

Rao, N. (2003). 'Half-truths" in Argentina, Brazil and India: An intercultural analysis of physician-patient communication. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural communication: A reader* (10th ed., pp.309–319). Belmont, CA: Thomson Wadsworth.

Rao, N., & Beckett, C.S. (2000). *Neither a difficult patient nor a difficult doctor: The role o f culture in effective doctor-patient communication*. Unpublished manuscript. Ohio University.

Read, B. L. (2018). Serial Interviews: When and Why to Talk to Someone More Than Once. *International Journal of Qualitative Methods*. https://doi.org/10.1177/1609406918783452

Region of the Tirol (2018). Population in the Tirol. Retrieved from www.tirol.gv.at/statistik-budget/statistik/wohnbevoelkerung

Reichard, R. J., Dollwet, M., & Louw-Potgieter, J. (2014). Development of cross-cultural psychological capital and its relationship with cultural intelligence and ethnocentrism. *Journal of Leadership & Organizational Studies, 21*, 150–164

Reid, R. L. (2005). The pain of rising healthcare costs. *Scrap*, *62*, 54–60.

Richards, L. (2016). Closeness to data: The changing goals of qualitative data handling. *Qualitative Health Research*, *8*(3), 319–328. https://doi.org/10.1177/104973239800800303

Risberg, G., Johansson, E.E., & Hamberg, K. (2009). A theoretical model for analysing gender bias in medicine. *International Journal for Equity in Health*, *8*, 28. https://doi.org/10.1186/1475-9276-8-28

Rivadeneyra, R., Elderkin-Thompson, V., Silver, R.C., & Waitzkin, H. (2000). Patient centeredness in medical encounters requiring an interpreter. *The American Journal of Medicine*, *108*(6), 470–474. https://doi.org/10.1016/S0002-9343(99)00445-3

Roberts, C.A., & Aruguete, M.S. (2000). Task and socioemotional behaviors of physicians: A test of reciprocity and social interaction theories in analogue physician-patient encounters. *Social Science & Medicine*, *50*(3), 309–315.

Rocque, R., & Leanza, Y. (2015). A systematic review of patients' experiences in communicating with primary care physicians: Intercultural encounters and a balance between vulnerability and integrity, *PloSONE,10*(10). e0139577. doi:10.1371/ journal.pone.0139577

Röder, A., & Mühlau, P. (2012). Low expectations or different evaluations: What explains immigrants' high levels of trust in host-country institutions? *Journal of Ethnic and Migration Studies*, *38*(5), 777–792. https://doi.org/10.1080/1369183X.2012.667986

Rogg, L., Aasland, O.G., Graugaard, P.K., & Loge, J.H. (2010). Direct communication, the unquestionable ideal? Oncologists' accounts of communication of bleak prognoses. *Psycho-Oncology*, *19*(11), 1221–1228. https://doi.org/10.1002/pon.1691

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, *53*(3), 304–310. https://doi.org/10.1111/j.1365-2648.2006.03727.x

Roter, D. (2000). The enduring and evolving nature of the patient–physician relationship. *Patient education and counseling*, *39*(1), 5–15. https://doi.org/10.1016/S0738-3991(99)00086-5

Roter, D., & Hall, J.A. (2006). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits* (2nd ed.). Westport, CT: Praeger.

Roter, D.L., & Hall, J.A. (1992). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits*. Westport, CT: Auburn House.

Roter, D.L., & Hall, J.A. (2004). Physician gender and patient-centered communication: A critical review of empirical research. *Annual Review of Public Health*, *25*, 497–519. https://doi.org/10.1146/annurev.publhealth.25.101802.123134

Rubin, H.J., & Rubin, I.S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage.

Rubin, H.J., & Rubin, I.S. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.). Thousand Oaks, CA: Sage.

Rustemeyer, R. (1992). *Praktisch-methodische Schritte der Inhaltsanalyse: Eine Einführung am Beispiel der Analyse von Interviewtexten*. Münster: Aschendorff.

Ryan, G.W., & Bernard, H.R. (2016). Techniques to identify themes. *Field Methods*, *15*(1), 85–109. https://doi.org/10.1177/1525822X02239569

Saha, S., Beach, M.C., Cooper, LA. (2008). Patient centeredness, cultural competence and healthcare quality. *J. Natl Med Assoc, 100*, 1275-1285.

Salander, P., & Hamberg, K. (2005). Gender differences in patients' written narratives about being diagnosed with cancer. *Psycho-Oncology*, *14*(8), 684–695. https://doi.org/10.1002/pon.895

Salimbene, S. (2000). *What language does your patient hurt in? A practical guide to culturally competent patient care*. Amherst, MA: Diversity Resources.

Samovar, LA., Porter, RE., McDaniel, E.R., & Roy, CS. (2017). *Communication between Cultures*. Boston: Wadsworth, 103–169.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, *8*(3), 27–37. https://doi.org/10.1097/00012272-198604000-00005

Sandhu, H., Adams, A., Singleton, L., Clark-Carter, D., & Kidd, J. (2009). The impact of gender dyads on doctor-patient communication: A systematic review. *Patient Education and Counseling*, *76*(3), 348–355. https://doi.org/10.1016/j.pec.2009.07.010

Schatzman, L., & Strauss, A. L. (1973). *Field research: Strategies for a natural sociology*. Englewood Cliffs, N.J: Prentice-Hall.

Schoen, C., Osborn, R., Huynh, P.T., Doty, M., Zapert, K., Peugh, J., & Davis, K. (2005). Taking the pulse of health care systems: Experiences of patients with health problems in six countries. *Health Affairs*, *24*(Suppl1 Web Exclusives), W5-509-525. https://doi.org/10.1377/hlthaff.w5.509

Schouten, B.C., & Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. *Patient Education and Counseling*, *64*(1-3), 21–34. https://doi.org/10.1016/j.pec.2005.11.014

Schouten, B.C., Meeuwesen, L., & Harmsen, H.A.M. (2009). GPs' interactional styles in consultations with Dutch and ethnic minority patients. *Journal of Immigrant and Minority Health*, *11*(6), 468–475. https://doi.org/10.1007/s10903-008-9131-9

Schreier, M. (2014). Qualitative content analysis. In U. Flick (Ed.), *The SAGE handbook of qualitative data analysis* (pp.170–183). London: Sage. https://doi.org/10.4135/9781446282243.n12

Scollon, R., & Scollon, S.W. (2001). *Intercultural communication: A discourse approach* (2nd ed.). Malden, MA: Blackwell.

Seale, C. (2004). *Social research methods: A reader*. London: Routledge.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York: Teachers College Press.

Seijo, R., Gomez, H., & Freidenberg, J. (2016). Language as a communication barrier in medical care for Hispanic patients. *Hispanic Journal of Behavioral Sciences*, *13*(4), 363–376. https://doi.org/10.1177/07399863910134001

Servellen, G.M. van. (1997). *Communication skills for the health care professional: Concepts and techniques*. Gaithersburg, MD: Aspen Publishers.

Shah, N.R., Hirsch, A.G., Zacker, C., Wood, G.C., Schoenthaler, A., Ogedegbe, G., & Stewart, W.F. (2009). Predictors of first-fill adherence for patients with hypertension. *American Journal of Hypertension*, *22*(4), 392–396. https://doi.org/10.1038/ajh.2008.367

Sharf, B. F. (1993). Reading the vital signs: Research in health care communication. *Communication Monographs*, *60*(1), 35–41. https://doi.org/10.1080/03637759309376292

Silverman, D. (1989). Six rules of qualitative research: A post-romantic argument. *Symbolic Interaction*, *12*(2), 215–230. https://doi.org/10.1525/si.1989.12.2.215

Silverman, D. (2006). *Interpreting qualitative data: Methods for analyzing talk, text and interaction* (3rd ed.). London: Sage.

Slatore, C.G., Cecere, L.M., Reinke, L.F., Ganzini, L., Udris, E.M., Moss, B.R., Au, D.H. (2010). Patient-clinician communication: Associations with important health outcomes among veterans with COPD. *Chest*, *138*(3), 628–634. https://doi.org/10.1378/chest.09-2328

Smith, B.A. (1999). Ethical and methodologic benefits of using a reflexive journal in hermeneutic-phenomenologic research. *Image--the Journal of Nursing Scholarship*, *31*(4), 359–363.

Solis, J.M., Marks, G., García, M., & Shelton, D. (1990). Acculturation, access to care, and use of preventive services by Hispanics: Findings from HHANES 1982-84. *American Journal of Public Health*, *80*(Supplement), 11–19. https://doi.org/10.2105/ajph.80.suppl.11

Sommer, J., Macdonald, W., Bulsara, C., Lim, D., (2012). Grunt language versus accent: the perceived communication barriers between international medical graduates and patients in Central Wheatbelt catchment s.Aust. *J Prim Health, 18*(3), 197-203. https://doi.org/10.107/py11030PMID:2306962

Spallek, J., Zeeb, H., & Razum, O. (2010). Prevention among immigrants: the example of Germany. *BMC Public Health, 10*, 92.

Spector, R.E. (2000). *Cultural diversity in health & illness* (5th ed.). Upper Saddle River, NJ: Prentice Hall Health.

Spector, R.E. (2004). *Cultural diversity in health and illness* (6th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Spencer-Oatey, H., & Franklin, P. (2009). *Intercultural Interaction: a Multidisciplinary Approach to Intercultural Communication*. Basingstoke: Palgrave Macmillan.

Spitzberg, B.H., & Hecht, M.L. (1984). A component model of relational competence. *Human Communication Research*, *10*(4), 575–599. https://doi.org/10.1111/j.1468-2958.1984.tb00033.x

Spradley, J.P. (1979). *The ethnographic interview*. Fort Worth, FL: Harcourt Brace Jovanovich College Pub.

Statistics Austria (2018). Migration. Retrieved from www.statistik.at/web_en/statistics/PeopleSociety/population/migration/index.htm

Stewart, A.L., Nápoles□Springer, A., & Pérez□STable, E.J. (1999). Interpersonal processes of care in diverse populations. *The Milbank Quarterly*, *77*(3), 305–339. https://doi.org/10.1111/1468-0009.00138

Street, R.L. (2001). Active patients as powerful communicators. In W. P. Robinson & H. Giles (Eds.), *The new handbook of language and social psychology* (pp.541–561). Chichester: Wiley.

Street, R.L. (2002). Gender differences in health care provider-patient communication: Are they due to style, stereotypes, or accommodation? *Patient Education and Counseling*, *48*(3), 201–206. https://doi.org/10.1016/S0738-3991(02)00171-4

Street, R.L., Cauthen, D., Buchwald, E., & Wiprud, R. (1995). Patients' predispositions to discuss health issues affecting quality of life. *Family Medicine*, *27*(10), 663–670.

Street, R.L., & Millay, B. (2001). Analyzing patient participation in medical encounters. *Health Communication*, *13*(1), 61–73. https://doi.org/10.1207/S15327027HC1301_06

Street, Jr. RL., Gordon, H.S., Ward, MM., Krupat, E., & Kravitz, RL. (2005). Patient participation in medical consultations: why some patients are more involved than others. *Medical Care, 43*, 960-969.

Streubert, H.J., & Carpenter, D.R. (1995). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: Lippincott.

Suarez-Orozco, M.M. (1989). *Central American Refugees and U.S. High Schools. A Psychosocial Study of Motivation and Achievement*. Stanford: Stanford University Press.

Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology*, *34*(2), 237–245. https://doi.org/10.1002/jcop.20095

Swenson, S.L., Buell, S., Zettler, P., White, M., Ruston, D.C, Lo, B. (2004). Patient-centered Communication: Do Patients really prefer it? *J Gen Intern Med, 19*(11), 1069-1079. https://doi.org/10.1111/j.1525-1497.2004.30384.xPMID:15566435

Szczepura, A. (2005). *An overview of the research evidence on ethnicity and communication in healthcare: Final report*. Warwick: University of Warwick.

Taft, R. (1966). *From stranger to citizen. A survey of studies of immigrant assimilation in Western Australia*. London: Tavistock Publications.

Tannen, D. (1991). *You just don't understand: Women and men in conversation* (Vol. 17). New York, NY: Ballantine Books.

Tasso, K.H., & Behar-Horenstein, L.S. (2008). Attributes of patient-physician interactions in a teaching hospital. *Hospital Topics*, *86*(1), 21–28. https://doi.org/10.3200/HTPS.86.1.21-28

Teal, CR., & Street, RL. (2009). Critical elements of culturally competent communication in the medical encounter: A review and model. *Social Sciences Medicine, 68*, 533-543.

Temple, B., & Edwards, R. (2002). Interpreters/translators and cross-language research: Reflexivity and border crossings. *International Journal of Qualitative Methods*, *1*(2), 1–12. https://doi.org/10.1177/160940690200100201

Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. New York, NY: Falmer Press.

Thornton, R.L.J., Powe, N.R., Roter, D., & Cooper, L.A. (2011). Patient-physician social concordance, medical visit communication and patients' perceptions of health care quality. *Patient Education and Counseling*, *85*(3), e201-8. https://doi.org/10.1016/j.pec.2011.07.015

Ting-Toomey, S. (1994). Managing intercultural conflicts effectively. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural communication: A reader* (7th ed., pp.360–372). Stamford, CT: Wadsworth Thomson Learning.

Tobin, G.A., & Begley, C.M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, *48*(4), 388–396. https://doi.org/10.1111/j.1365-2648.2004.03207.x

Tocher, T.M., & Larson, E. (1998). Quality of diabetes care for non-English-speaking patients. A comparative study. *The Western Journal of Medicine*, *168*(6), 504–511.

Torres, M.B. (2004). *Doctors communicating with culturally diverse patients: Towards understanding culture competent communication in doctor and patient interaction* (Doctoral disseration). University of Ohio, Ohio.

Torres, M.B., Rao, N. (2007). Disclosure and Truth in Physician-Patient Communication: An Exploratory in Argentina, Brazil, India and the U.S. *Journal of Creative Communiations, 2*(3), 279-305. https://doi.org/10.1177/097325860700200302

Tuckett, A.G. (2005). Part II. Rigour in qualitative research: Complexities and solutions. *Nurse Researcher*, *13*(1), 29–42. https://doi.org/10.7748/nr2005.07.13.1.29.c5998

Ulrey, K.L., & Amason, P. (2001). Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. *Health Communication*, *13*(4), 449–463.

Van Dalen, J. (2013). Communication skills in context: Trends and perspectives. *Patient Education and Counseling*, *92*(3), 292–295. https://doi.org/10.1016/j.pec.2013.05.020

Van den Brink□Muinen, A., Maaroos, H.I., & Tähepõld, H. (2008). Communication style in primary health care in Europe. *Health Education*, *108*(5), 384–396. https://doi.org/10.1108/09654280810900008

Van Manen, M. (2014). *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Walnut Creek, CA: Left Coast Press.

Van Wieringen, J.C.M., Harmsen, H.A.M., & Bruijnzeels, M.A. (2002). Intercultural communication in general practice. *European Journal of Public Health*, *12*(1), 63–68. https://doi.org/10.1093/eurpub/12.1.63

Vanderford, M.L., Jenks, E.B., & Sharf, B.F. (1997). Exploring patients' experiences as a primary source of meaning. *Health communication*, *9*(1), 13–26. https://doi.org/10.1207/s15327027hc0901_2

Vanderford, M.L., Stein, T., Sheeler, R., & Skochelak, S. (2001). Communication challenges for experienced clinicians: Topics for an advanced communication curriculum. *Health Communication*, *13*(3), 261–284. https://doi.org/10.1207/S15327027HC1303_3

Veal, A.J. (2005). *Business research methods: A managerial approach* (2nd ed.). Frenchs Forest, NSW: Pearson/Addison Wesley.

Verkuyten, M., & Thijs, J. (2010). Ethnic Minority Labeling, Multiculturalism, and the Attitude of Majority Group Members. *Journal of Language and Social Psychology*, *29*(4), 467–477. https://doi.org/10.1177/0261927X10377992

Verlinde, E., Laender, N. de, Maesschalck, S. de, Deveugele, M., & Willems, S. (2012). The social gradient in doctor-patient communication. *International Journal for Equity in Health*, *11*, 12. https://doi.org/10.1186/1475-9276-11-12

Vickers, K.A., Jolly, KB., & Greenfield, SM. (2006). Herbal medicine: women's views, knowledge and interaction with doctors: a qualitative study. *BMC Complement Altern Med, 6*, 1–8.

Vogt, W.P., Voght, E.R., Gardner, D.C., & Haeffele, L.M. (2014). *Selecting the right analyses for your data: Quantitative, qualitative, and mixed methods*. New York, London: The Guilford Press.

Walker, K.L., Arnold, C.L., Miller-Day, M., & Webb, L.M. (2002). Investigating the physician-patient relationship: Examining emerging themes. *Health communication*, *14*(1), 45–68. https://doi.org/10.1207/S15327027HC1401_3

Walters, A.J. (1995). The phenomenological movement: Implications for nursing research. *Journal of Advanced Nursing*, *22*(4), 791–799. https://doi.org/10.1046/j.1365-2648.1995.22040791.x

Wanzer, M.B., Booth-Butterfield, M., & Gruber, K. (2004). Perceptions of health care providers' communication: Relationships between patient-dentered communication and satisfaction. *Health communication*, *16*(3), 363–384. https://doi.org/10.1207/S15327027HC1603_6

Watson, B.M., & Gallois, C. (1998). Nurturing communication by health professionals toward patients: A communication accommodation theory approach. *Health Communication*, *10*(4), 343–355. https://doi.org/10.1207/s15327027hc1004_3

Watson, B.M., & Gallois, C. (2007). Language, discourse, and communication about health and illness: Intergroup relations, role, and emotional support. In A. Weatherall, B. M. Watson, & C. Gallois (Eds.), *Language, Discourse and Social Psychology* (pp.108–130). London: Palgrave Macmillan.

Watzlawick, P., Bavelas, J.B., & Jackson, D.D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes*. New York: Norton.

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. London: Sage.

Whaley, B.B. (2000). Explaining illness to children. In B. B. Whaley (Ed.), *Explaining illness: Research, theory, and strategies* (pp.194–208). Mahwah, N.J: Lawrence Erlbaum Associates.

Wheatley, R.R., Kelley, K.A., Peacock, N., & Delgado, J. (2008). Women's narratives on quality in prenatal care: a multicultural perspective. *Qual Health Res, 18*(11), 1586-1598. https://doi.org/10.1177/1049732308324986.PMID:18849519

Whittal, A., & Rosenberg, E. (2015). Effects of individual immigrant attitudes and host culture attitudes on doctor-immigrant patient relationships and communication in Canada. *International Journal for Equity in Health*, *14*, 108. https://doi.org/10.1186/s12939-015-0250-3

Wiking, E., Saleh-Stattin, N., Johansson, S.E., & Sundquist, J. (2009). Immigrant patients' experiences and reflections pertaining to the consultation: A study on patients from Chile, Iran and Turkey in primary health care in Stockholm, Sweden. *Scandinavian journal of caring sciences*, *23*(2), 290–297. https://doi.org/10.1111/j.1471-6712.2008.00622.x

Williams, S., Weinman, J., & Dale, J. (1998). Doctor-patient communication and patient satisfaction: A review. *Family Practice*, *15*(5), 480–492. https://doi.org/10.1093/fampra/15.5.480

Witte, K., & Morrison, K. (1995). Intercultural and cross-cultural healthcommunication: Understanding people and motivating healthy behaviors. In R. Wiseman (Ed.), *Intercultural communication theory* (pp.216–246). Thousand Oaks, CA: Sage.

Witzel, A. (2000). The problem-centered interview. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *1*(1), Art. 22. https://doi.org/10.17169/fqs-1.1.1132

Wolf, Z.R. (2003). Exploring the audit trail for qualitative investigations. *Nurse Educator*, *28*(4), 175–178.

Yin, R.K. (1994). *Case study research: Design and methods* (2nd ed.). Thousand Oaks, CA: Sage.

Yorkston, KM., Johnson, K., Boesflug, E., Skala, J., & Amtmann, D. (2010). Communicating about the experience of pain and fatigue in disability. *Qual Life Res, 19*(2), 243–251. https://doi.org/10.1007/s11136-009-9572-1 PMID:20033786

Young, A., & Flower, L. (2002). Patients as partners, patients as problem-solvers. *Health communication*, *14*(1), 69–97. https://doi.org/10.1207/S15327027HC1401_4

Zanchetta, M.S., & Poureslami, I.M. (2006). Health literacy within the reality of immigrants' culture and language. *Canadian Journal of Public Health = Revue Canadienne De Sante Publique*, *97 Suppl 2*(3), 26-30. https://doi.org/10.1007/BF03405370

Žebiene, E., Švab, I., Šapoka, V., Kairys, J., Dotsenko, M., Radić, S., & Miholič, M. (2008). Agreement in patient–physician communication in primary care: A study from Central and Eastern Europe. *Patient education and counseling*, *73*(2), 246–250. https://doi.org/10.1016/j.pec.2008.07.034

Ziefle, M., & Schaar, A.K. (2011). Gender differences in acceptance and attitudes towards an invasive medical stent. *Electronic Journal of Health Informatics*, *6*(2), e13.

Zoppi, K., & Epstein, R.M. (2002). Is communication a skill? Communication behaviors and being in relation. *Family Medicine*, *34*(5), 319–324.

10 Appendices

Appendix 1

Edinburgh Napier UNIVERSITY

Information Sheet for General Practitioners

Title of Project: **The role of culture in the communication process in a medical encounter.**

My name is Leena Saurwein and I am a doctoral student from the School of Business at Edinburgh Napier University. As part of my degree course, I am undertaking a research project for my PhD dissertation. The title of my project is: **The role of culture in the communication process in a medical encounter.**

This study aims to understand the experiences of General Practitioners and women immigrants in a medical consultation such that it can explore the ways in which the meaning of culture is created in health care interactions in the doctor-patient medical encounter. The findings of the project will be valuable because such a study has not been conducted in the Tirol, yet, and it could give valuable insights for future research and changes.

If you agree to participate in the study, you will be asked to first fill in the documentation sheet containing demographic details. Then, you will be requested to answer some questions regarding your culture, consultation process, experiences and communication strategies. Your interview will be audio recorded so that the researcher can accurately present and understand your perspectives. After the interview, the researcher will also make a note of the setting and the participant's behaviour in the section post-script. Next, she will transcribe your interview and mail a copy of the transcription to you for approval. The researcher will also hand you a list and definition of technical terms that may be used during the interview and interview questions.

There may be some inconvenience for participants, as in some cases the disclosure of participants' experiences with their patients can make them feel a bit uncomfortable and perhaps anxious. The whole interview procedure should take no longer than 30 – 40 minutes. You will be free to withdraw from the study at any stage; you would not have to give a reason.

All data will be anonymised. Your name will be replaced with a participant number (an alphanumeric code) and it will not be possible for you to be identified in any reporting of the data gathered. The raw data, however, will be initially shared between the researcher and her two supervisors in the form of transcripts for analysis and interpretation of the data. All data collected will be kept in a secure place as it will be stored on the researcher's PC that is password protected, to which only the researcher has access. These will be kept till the end of the examination process, following which all data that could identify you will be destroyed.

The results may be published in a journal or presented at a conference.

If you would like to contact an independent person, please contact Dr Matthew Dutton at +44 [redacted].

If you have read and understood this information sheet, any questions you had, have been answered, and you would like to be a participant in the study, please now see the consent form.

Edinburgh Napier UNIVERSITY

Appendix 2

Consent Form for General Practitioners

"The role of culture in the communication process in a medical encounter."

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I agree that known risks to me have been explained to my satisfaction and I understand that I am under no obligation to take part in this study.

I have been told that my responses will be anonymized and that I will not be identifiable in any report subsequently produced by the researcher. I understand that I have the right to withdraw from this study at any stage without giving any reason.

I freely and voluntarily consent to be a participant in this research.

My signature is not a waiver of any legal rights. I understand that I will be able to keep a copy of the informed consent form for my records.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher

Name of researcher: Leena Saurwein

Address: Doctoral Student, School of Business
Edinburgh Napier University
Craiglockhart Campus
Colinton Road
Edinburgh EH14 1DJ

Email / Telephone: [redacted]

Appendix 3

Edinburgh Napier UNIVERSITY

Information Sheet for Women Immigrants

Title of Project: **The role of culture in the communication process in a medical encounter.**

My name is Leena Saurwein and I am a doctoral student from the School of Business at Edinburgh Napier University. As part of my degree course, I am undertaking a research project for my PhD dissertation. The title of my project is: **The role of culture in the communication process in a medical encounter.**

This study aims to understand the experiences of women immigrants and General Practitioners in a medical consultation such that it can explore the ways in which the meaning of culture is created in health care interactions in the doctor-patient medical encounter. The findings of the project will be valuable because such a study has not been conducted in the Tirol, yet, and it could give valuable insights for future research and changes.

If you agree to participate in the study, you will be asked to first fill in the documentation sheet containing demographic details. Then, you will be requested to answer some questions regarding your culture, consultation process, experiences and communication strategies. Your interview will be audio recorded so that the researcher can accurately present and understand your perspectives. After the interview, the researcher will also make a note of the setting and the participant's behaviour in the section post-script. Next, she will transcribe your interview and mail a copy of the transcription to you for approval. The researcher will also hand you a list and definition of technical terms that may be used during the interview and interview questions.

There may be some inconvenience for participants, as in some cases the disclosure of participants' experiences with their GPs can make them feel a bit uncomfortable and perhaps anxious. The whole interview procedure should take no longer than 30 – 40 minutes. You will be free to withdraw from the study at any stage; you would not have to give a reason.

All data will be anonymised. Your name will be replaced with a participant number (an alphanumeric code) and it will not be possible for you to be identified in any reporting of the data gathered. The raw data, however, will be initially shared between the researcher and her two supervisors in the form of transcripts for analysis and interpretation of the data. All data collected will be kept in a secure place as it will be stored on the researcher's PC that is password protected, to which only the researcher has access. These will be kept till the end of the examination process, following which all data that could identify you will be destroyed.

The results may be published in a journal or presented at a conference.

If you would like to contact an independent person, please contact Dr Matthew Dutton at +44 [redacted]

If you have read and understood this information sheet, any questions you had, have been answered, and you would like to be a participant in the study, please now see the consent form.

Edinburgh Napier UNIVERSITY

Appendix 4

Consent Form for Women Immigrants

"The role of culture in the communication process in a medical encounter."

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I agree that known risks to me have been explained to my satisfaction and I understand that I am under no obligation to take part in this study.

I have been told that my responses will be anonymized and that I will not be identifiable in any report subsequently produced by the researcher. I understand that I have the right to withdraw from this study at any stage without giving any reason.

I freely and voluntarily consent to be a participant in this research.

My signature is not a waiver of any legal rights. I understand that I will be able to keep a copy of the informed consent form for my records.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher

Name of researcher: Leena Saurwein

Address: Doctoral Student, School of Business
Edinburgh Napier University
Craiglockhart Campus
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Email / Telephone: [redacted]

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Ihr Zeichen, Ihre Nachricht	Unser Zeichen, Sachbearbeiter(in)	E-Mail-Adresse	Datum
21.12.2016	Dir. Dr. AM/	[redacted]	02.01.2017

Ethische Genehmigung für die Dissertation:
"Role of Culture in the Communication Process in a Medical Encounter"
(„Die Rolle der Kultur im Kommunikationsprozess in einer medizinischen Besprechung")

Sehr geehrte Frau Saurwein, MA

Gerne komme ich hiermit Ihrer Bitte, der ethischen Genehmigung Ihres Vorhabens nach.

In Bezug auf die oben genannte Forschungsarbeit wird hiermit folgendes erklärt:

Im Namen der Tiroler Gebietskrankenkasse, bestätige und erteile Ich, Dr. Arno Melitopulos, in meiner Rolle als Direktor der Tiroler Gebietskrankenkasse, Frau Leena Saurwein MA die ethische Genehmigung zur Befragung von Patientinnen mit Mitgrationshintergrund und der Erfassung und Auswertung der dabei erhobenen Daten.

Diese Genehmigung gilt im Rahmen und für die Dauer der Erstellung obengenannter Dissertation. Es handelt sich um eine Forschungsarbeit im Bereich interkulturelle Kommunikation. Medizinische Daten und Anamnesen werden dabei in keiner Weise erfasst.

Mit freundlichen Grüßen

Der Direktor:

[redacted]

(Dr. Arno Melitopulos)

Translation of the letter of consent issued by the Tirolean Health Insurance

The Tirolean Health Insurance
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Tel. + 43 (0) 59160-1609
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MCI Management Center
The entrepreneurial School
Attn: Leena Saurwein, MA
Universitaetstrasse 15
6020 Innsbruck

Re: ethical approval for the dissertation:

"Role of Culture in the Communication Process in a Medical Encounter"

Dear Mrs Saurwein, MA

I am happy to meet your request for ethical approval for your undertaking.

With reference to the aforementioned research work the following can be declared:

On behalf of the Tirolean Health Insurance, I, Dr. Arno Melitopulos, in my role as the Director of the Tirolean Health Insurance, hereby confirm and grant Mrs. Leena Saurwein, MA the ethical approval for interviewing of patients with migrant background as well as for collecting and evaluating the generated data.

This approval is valid in the scope of the aforementioned dissertation and its duration. This research work deals with intercultural communication. Medical data and medical history will not be collected.

Yours sincerely
The Director

(Dr. Arno Melitopulos)

ÄRZTE KAMMER FÜR TIROL

Präsident

Dr. Artur WECHSELBERGER
Telefon: +43 512 520 58-129
Telefax: +43 512 520 58-130
E-Mail: praesident@aektirol.at
AZ: 8.2

Frau
Leena Saurwein, MA
MCI Management Center Innsbruck
Universitätsstraße 15
6020 Innsbruck

Geschäftszahl	*Ihr Schreiben*	*Datum*
00015645	-	*12.12.2016*

Ethische Genehmigung für die Dissertation:
"Role of Culture in the Communication Process in a Medical Encounter"
(„Die Rolle der Kultur im Kommunikationsprozess in einer medizinischen Besprechung")

In Bezug auf die oben genannte Forschungsarbeit wird hiermit Folgendes erklärt:

Im Namen der Ärztekammer für Tirol wird bestätigt, dass gegen eine Befragung von Ärztinnen und Ärzten für Allgemeinmedizin keine Bedenken bestehen.

Der Präsident:

[redacted]

Dr. Artur Wechselberger

Translation of the letter of consent issued by the Medical Chamber for the Tirol

Medical Chamber for the Tirol

President
Dr. Artur Wechselberger
Tel. +43 512 520 58-129
Fax: + 43 512 520 58-130
E-mail: president@aektirol.at
AZ:8.2

Mrs. Leena Saurwein, MA
MCI Management Center Innsbruck
Universitaetstrasse 15
6020 Innsbruck

Re: ethical approval for the dissertation:

"Role of Culture in the Communication Process in a Medical Encounter"

With reference to the aforementioned research work the following can be declared:

On behalf of the Medical Chamber for the Tirol, it can be confirmed that there are no objections against the interviewing of General Practitioners (m/f).

The President

Dr. Artur Wechselberger

Interview Guide

Indicative Interview Questions for General Practitioners

The following interview questions cover the topical areas of research. They are indicative as they may be amended and modified after two pilot interviews have been carried out.

Indicative Interview Questions:

- Describe your consultation process? What types of consultations do you find most difficult or challenging, and why? Can you describe some recent consultations in which you encountered difficulties?
- When do you believe you have had a successful interaction with a patient
- Do you feel any communication barriers between you and your patient? Which ones?
- What communication strategies do you use to reach your patients? Do you feel that your patients have understood your diagnosis and treatment regime?
- What is the most important thing that could be done to improve clinical communication with patients?
- Is it any different for female patients from different nationalities? If so then in what way?
- Are there any different aspects to what you believe is a successful interaction when the patient with a different cultural background?
- Do you feel there are any difficulties in establishing an effective relationship with a patient with a different cultural background?

Probing questions may be used in the interviews: Some **probing questions** may include:

- You mentioned….can you tell me a bit more about that?
- Would you like to talk some more about…?
- You used the word…can you tell me what you meant by that?

Concluding Remarks

I appreciate the time taken to talk to me. Your insight has been helpful for me in my research.

Thank you very much for the interview

Interview Guide

Indicative Interview Questions for Women Immigrants

The following interview questions cover the topical areas of research. They are indicative as they may be amended and modified after two pilot interviews have been carried out.

Indicative Interview Questions:

- Describe your experience of a recent consultation with a General practitioners.?
- What where your expectations?
- Do you feel that the interaction with your GP here is different from ones you experienced when you were in your country of origin? In what way?
- Can you describe some recent consultations in which you encountered difficulties?
- What do you think caused the difficulty? How could that have been avoided?
- Do you think your relationship with your doctor closer now than it was at the beginning? Why?

Probing questions may be used in the interviews: Some probing questions may include:

- You mentioned….can you tell me a bit more about that?
- Would you like to talk some more about…?
- You used the word…can you tell me what you meant by that?

Concluding Remarks

I appreciate the time taken to talk to me. Your insight has been helpful for me in my research. Thank you very much for the interview.

Transcription Rules and Examples Source adapted from Have (1999)

Layout	
Word processing	Word
Font	Times New Roman 12
Margin	Left 2, Right4
Line Number	1,2
Page numbers	Bottom right
Interviewer	I
Respondent	WI / GP
Transcription	
#...#	# hashtags before and after the word# When the speaker's talk is overlapped by another speaker
=	= Equal signs, at the end of a line and at the beginning of the next line indicate no gap between the two lines
(.4)	Numbers in parentheses indicate elapsed time in tenths of a second
(.)	A dot inside parentheses indicates a tiny gap, not more than one tenth of a second
_	Underscore indicates stress via pitch and/or amplitude
:	Colon indicate prolongation of the immediate prior sound e.g. O:kay?
WORD	Capitals, indicate loud sounds relative to the surrounding talk
.hhh e.g. I feel that (.2) .hhh	H's prefixed by a dot indicate in breadth. H's without a dot indicate an outbreath. The number of h's show length of in- or out-breadth
(incomp)	Parenthese with incomp means incomprehensible
(word)	The word in the bracket indicate possible hearings
(paralinguistic utterances)	(sighs)
((…))	Double parentheses indicate interviewers descriptions rather than transcription
.*	Dot and asterix indicate falling intonation
.+	Dot and plus indicate rising intonation
-	Hyphen indicates an abrupt cut-off of the sound in progress e.g. becau-
^	Circumflex or hat indicates a marked pitch rise
>	The greater than sign in the margin point to the lines of transcript relevant to the point made in the text
Names with °	Anonymization

Transcription Template

	Transcript	Space for other type of notes

Interview with GP_CR_08

LS: Wohl störend. Danke, nochma**ls**, dass Sie sich die Zeit genommen haben, ja.

CR: Bitte schön. Gerne.

LS: Könnten Sie mir eine Konsultation beschreiben, wie das generell bei Ihnen abläuft

CR: … ich verstehe Sie schon ...

LS: … so wenn eine Patientin zu Ihnen kommt?

CR: Ah, grundsätzlich gibt es zwei verschiedene Konsultationen. Die eine ist zu jemand hin, den wir schon kennen und dann gibt's natürlich – ah - neue Bekanntschaften, neue Begegnungen, gell.

LS: mhm.

CR: Ah, das geht dann sehr unterschiedlich natürlich – ah – Sie sprechen jetzt ganz generell die Prinzipien an oder denken hier schon an spezielle Problematiken von Menschen, Personen, die aus fremden Ländern und fremden Kulturen kommen?

LS: mm, ja, eigentlich zu dem wollte ich kommen, aber das passt eh, ja.

CR: Ja gut – ah – aber jetzt bleiben wir vielleicht beim Ersten – ah – das Privileg der Allgemein-Medizin ist ja, dass wir prinzipiell unsere Patienten kennen.

LS: mhm.

CR: Ah, und das ist ja etwas Schönes, weil da hat man die Kontinuität – ah – hier beobachtet man eine Bewegung, man ist auf einem Prozess der Erkenntnisse und der Bekanntschaften und je besser, je weiter man hier ist und je besser die Bekanntschaft ist, desto besser gelingt es auch – ist auch immer das Resultat.

LS: mhm, mhm.

CR: Bei den neuen Bekanntschaften ist – ah – ist natürlich immer eine gewisse Hürde des Kennenlernens …

LS: mhm …

CR: … ah – wenn ich an fremde Länder und fremde Kulturen denke, die in Österreich zum Hausarzt, zum Allgemein-Mediziner kommen, dann denke ich eigentlich in erster Linie gar nicht einmal an so offensichtlich schwer kranke Personen, …

LS: mhm …

CR: … sondern denke ich schon, dass die große Hürde – ah – natürlich die Kommunikation ist …

LS: mhm

CR: … und das ist jetzt vielleicht dieser große dritte Punkt, in den ich gleich ohne gefragt zu werden hinein stolpere …

LS: mhm …

CR: … ah – sind die Fragen der Kommunikation – ah – wir haben eben zuerst gehabt die Unterscheidung in neue und bekannte Patienten. Jetzt kommt der große nächste – von einem anderen Winkel aus - der große Bereich erstes Kennenlernen und die Frage der Kommunikation, wobei natürlich die Frage der Kommunikation auch dann die kontinuierliche, die Kontinuitäts-Betreuung genauso betrifft …

Interview with GP CR_08

LS: It does disturb. Thank you very much for giving me time.

CR: It is my pleasure.

LS: Could you please describe the process of a consultation, how it works in general.

CR: ..I do understand...

LS: ..when a female patient arrives.

CR: Well, we distinguish two different types of consultations. It can be either a first consultation or one, where we have known the patient already.

LS: mmm

CR: Well, depending on that the process is different. - Would you like to know the general principle or do you focus on specific problems, like having people from foreign countries or different cultural background.

LS: Well, yes, I did want to talk about that.

CR: Well - let us look into the first scenario for now. The advantage in working as a general practitioner lies in the fact, that we normally know our patients.

LS: mmm

CR: And this is really nice, because we have this kind of continuity, one can observe development, it is a process of finding answers and building relationships, and the better the knowledge and the relationship, the more successful is the outcome, the results are better.

LS: mmm

CR: If one meets a person for the first time, there is the obstacle of getting to know somebody, to build a relationship...

LS: mmm

CR: ,,,If I think of about people from different countries and different cultures, who see a general practitioner, a family doctor in Austria, I don't necessarily thing about people with severe illnesses....

LS: mmm

CR: ....I do rather think about a huge communication problem, about a language barrier....

LS: mmm

CR: ...and that's the key issue, I address, without even having been asked....

LS: mmm

CR: ...it's the issue of communication, as I said, we distinguish between patients coming for the first time and patients which have already been in the practice. Now -from a different angle- the next key issue, the wide field of getting to know each other, building a relationship in relation to communication, which, of course, plays a big role in the future continuous medical care as well.

Interview with KF

KF: Well do I even meet the criteria here?

LS: Uh, how long have you been here? ten years, less than ten years?

KF: Yeah, I've had one general practitioner but they went out of business.

LS: That's fine, tell me all about your experiences and more

KF: Okay

LS: Because the thing is I am analysing culture and to what extent it plays a role in the communication process between immigrants, like us, and uh the general practitioner in the communication process basically in a medical setting so

KF: Okay, I have a couple of stories (laughs)

LS: I'd love to listen to that

KF: Okay let's set a time though, when do you need to be gone?

LS: No no no. That's fine. I just told them I can't make it before two 'o' clock in the afternoon. Doesn't mean I'll be here because I've got to grab lunch and then leave after that. You can't just send me a meeting out of the blue. So that's fine. Umm, so if you could describe a consultation process, you know, that you've had here.

KF: Okay, for a general practitioner?

LS: Right

KF: Or let's say for the OBGYN like gynaecology…?

LS: A general practitioner.

KF: General practitioner, umm that was a neutral experience where it was very umm basic. Yeah, you come in, you fill out the paper-work, umm it takes about five minutes extra than normal, on a normal appointment. Umm they check through everything and then the secretaries file me away and uh I see the doctor.

LS: Okay and what was it like when you met the doctor?

KF: Umm I actually really, I felt that it was quite and open setting, but architecturally the doctor tried to make it private. Umm so I think there was more of a waiting room in a hallway, umm

and the secretary was actually his daughter umm and she would just take my paperwork and then I'd go back out and wait outside and then the doctor would call me in, umm but it was more sliding doors, so you'd have to go through one room to get to the next room. Umm so whomever he'd call in next would have to go by me into the next room. Uh and it was more or less just basic, he's asked me some standard questions and then I could elaborate on anything necessary. Quite standard.

LS: Mhmm, what do you mean by quite standard?

KF: Well he asked about basic health conditions and then I had to offer a couple of things, like what I'm allergic too, which I thought was culturally quite different because in America you always ask 'what are you allergic too?' first. Alright and he didn't even ask, and so I thought maybe I should offer that I'm allergic to this medication before he prescribes me something (laughs). Umm yeah it was, you could tell that it was in a densely populated area because his time, you know, was quite limited but he was still trying to be personal by, you know, holding eye contact with me umm and sitting at the same level and he tried to make it a bit personal, right. But I could still tell, okay these are standard questions that I just need to answer like how old I am and things like that. I think he was more confirming what was on the paper, just to make sure I understood as well. Some of those were tricky in German I have to say and umm I think I asked his daughter, the secretary, a question about it and uh she was able to clarify everything so. I mean it was family oriented.

LS: Okay, so the whole family was in the business so to say or…?

KF: Well the father and the daughter but it was still, it was kinda seedy. It was in a nice part of town, but it was still like, his clientele, his customers his clientele, they were a lot of, I can't say homeless but they seemed like they were, strung up on something.

LS: Mhmm

KF: And I wasn't sure is this doctor prescribing things just so people can have them or does he really care. Because if he were to just prescribe me something I would want him to know my allergies. It just seems that he was kind of, yeah it was more like an assembly line, right? And he didn't necessarily specify his cliental, it's just I guess, who goes to him, who lives in the area. It was around a big shopping centre and a park, so. And I think the a-by-zant (?) was near-by. I think it was just the location.

Documentation Sheet on Interviews	
Date of Interview	
Place of Interview	
Time of Interview **Beginning……End……**	
Total Duration of Interview:	
Name of the Interviewee:	
Indicator for the Interviewee (ID):	
Age of the Interviewee:	
Profession of the Interviewee:	
Working in this profession since:	
Professional Field:	
Country of birth	
Living in Austria since:	
Special Occurrences in the interview: / Post-script:	

The above documentation sheet will be filled in by the researcher, before and after the interview. The demographic details of the participants will also be taken prior to the

One-way Non-Disclosure Agreement

Date: ……2018

Parties: Leena Saurwein & ……..

[NAME OF INDIVIDUAL RECEIVING INFORMATION] residing at **[address of individual]** , hereinafter the Recipient

and

Leena Saurwein, MA residing at Hofwaldweg 33, 6020 Innsbruck, hereinafter the Discloser

1. The Discloser intends to disclose information the Confidential Information which is audio recordings to the Recipient for the purpose of transcription of the recordings for the Discloser's dissertation.

2. The Recipient undertakes not to use the Confidential Information for any purpose except the Purpose, without first obtaining the written agreement of the Discloser.

3. The Recipient undertakes to keep the Confidential Information secure and not to disclose it to any third party.

4. The undertakings in clauses 2 and 3 above apply to all of the information disclosed by the Discloser to the Recipient, regardless of the way or form in which it is disclosed or recorded.

5. The Recipient will, on request from the Discloser, return all copies and records of the Confidential Information to the Discloser and will not retain any copies or records of the Confidential Information.

6. Neither this Agreement nor the supply of any information grants the Recipient any licence, interest or right in respect of any intellectual property rights of the Discloser except the right to copy the Confidential Information solely for the Purpose.

7. The undertakings in clauses 2 and 3 will continue in force indefinitely.

Signed and Delivered as a Deed by:

[name of Recipient]

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Signature Location & Date

Archival Information Sheet			
Study: Phd research on the role of culture in the communication process in a medical setting **Archival: Details on the interviewees**			
Participant: Women Immigrants **Gender: Females** **Age: varied** **Nationality: varied** **Profession: varied** **Language: predominantly in English, a few in German**			
Data in the Envelope:			
Data Collector:			
Transcriber:	Hanna Gäbelein, Sarah Agath, Sigrid Schaubelt & Mahika Arora		
Translator:			
Hardcopy of Electronic Data:			
Electronic Data File:	**Interviews conducted from April 2017 – February 2018**		
Handwritten interview notes:	Notes taken after every interview and they are saved in the memos in the computer software NVivo		
Expanded field notes:			
Additional correspondence(e-mails etc):	Email correspondence for request and changes etc. are also stored in the external hard drive plus on the H drive at work and on the back-up external hard drive.		

Archival Log

Archival	Category	Interviewer	Transcriber	Translator	Date of Interview	Language of Interview	Participant	Sex	Age	Date of Management	Electronic Data File
1.	WI_IR_01	LS	Hanna Gäbelein	_	07.04.2017	English		Female	31		07.04.2017
2.	WI_NZ_02	LS	Sarah Agath	_	12.04.2017	English		Female	32		12.04.2017
3.	WI_BDL_03	LS	Sigrid Schnaubelt	_	06.06.2017	English		Female	32		06.06.2017
4.	WI_AI_04	LS	Sigrid Schnaubelt	_	01.08.2017	English		Female	29		01.08.2017

Codebook GP_2

Name	Description	Node Type	Nickname	Hierarchical Name	Number Of Sources Coded	Number Of Coding References
Acculturation	How GPs perceive patients who have been living here long	Node		Nodes\\Patients\Acculturation	1	1
Communication Barriers	The obstacles GPs face when communicating with people who do not speak German	Node		Nodes\\GP Constraints\Communication Barriers	5	8
Communication Strategies of GPs	Kind of measures taken by GPs to communicate with immigrants	Node	CSGP	Nodes\\Interaction\Communication Strategies of GPs	8	78
Empathy	By trying to understand the patient by putting oneself in his/her shoes so to say	Node		Nodes\\Personal Relationship\Empathy	1	3
Ethnicity-Nationality	The orgin of the patient or the ethnic group the patient belongs to	Node		Nodes\\Patients\Ethnicity-Nationality	8	76
Familiarity	The known face or regular patient who visits the doctor	Node		Nodes\\Personal Relationship\Familiarity	3	8
Fear and Anxiety	The Angst and uncertainity experienced by the women immigrants when they visit the GP and perceived by the GPs.	Node		Nodes\\GP Constraints\Fear and Anxiety	4	12
Gender	Here it is more the role of the woman; the tasks and the responsibilities she carries	Node		Nodes\\Patients\Gender	2	14
GP Constraints	The barriers and constraints the GPs face during their consultation.	Node		Nodes\\GP Constraints	0	0
GP Consultation Procedure and Medical Approach	The entire process of the visit, the talk with the patient, the diagnosis and the treatment regimen as well as the medical mindset of the GPS.	Node		Nodes\\GP Consultation Procedure and Medical Approach	8	110
Illness perception	The way the illness is seen and perceived as by the patient according to the GP	Node		Nodes\\Patients\Illness perception	7	28

Name	Description	Node Type	Nickname	Hierarchical Name	Number Of Sources Coded	Number Of Coding References
Interaction	The talk and communication as well as strategies such as verbal and nonverbal used by GPs to convey their message to their patients in this case the women immigrants	Node		Nodes\\Interaction	0	0
Language Barriers	Difficulties in Understanading and expression oneself	Node		Nodes\\GP Constraints\Communication Barriers\Language Barriers	7	24
Listening	Paying attention to the patients and actively listening to them	Node		Nodes\\Personal Relationship\Listening	3	5
Migration	The current refugee issue that prevails in Austria	Node		Nodes\\Miscelleanous\Migration	2	7
Miscelleanous	Not directly connected to the topics	Node		Nodes\\Miscelleanous	4	14
Patient Compliance	How patients understand the treatment regimen and then follow the treatment. The healing process is also part of compliance	Node		Nodes\\Patient Compliance	8	22
Patient Expectations	What the patients expect from the doctors from the viewpoint of the doctors	Node		Nodes\\Patient Expectations	6	23
Patient Personality	the way the GP sees the patient's characteristics/attributes	Node		Nodes\\Patients\Patient Personality	5	9
Patients	The various kinds of patients that come to the GP	Node		Nodes\\Patients	0	0
Patients' Education	the level of education the patient has and the GPs awareness of it	Node		Nodes\\GP Constraints\Patients' Education	5	15
Personal Relationship	The professional personal relation shared by the GP with his/her patient	Node		Nodes\\Personal Relationship	0	0
Role	The role of the GP towards the patient i.e. hierarchical or mentor etc	Node	Role GP	Nodes\\GP Constraints\Role	5	8
Social Security System	The social security system in Tirol, Austria which is responsible for the healthcare setting in general	Node		Nodes\\Social Security System	5	16

Name	Description	Node Type	Nickname	Hierarchical Name	Number Of Sources Coded	Number Of Coding References
Structural Differences	Structural differences in the social security systems between Austria and the rest of the world and within the systems available in Austria - BVA	Node		Nodes\\Social Security System\Structural Differences	2	3
Time	Time required for the entire consultation	Node		Nodes\\GP Constraints\Time	6	8
Translator	Use of translators to get the message across	Node		Nodes\\GP Constraints\Translator	7	15
Treatment regimen	The treatment prescribed to the patient	Node		Nodes\\GP Constraints\Treatment regimen	7	18
Trust	The belief/faith that is build up in the GP	Node		Nodes\\Personal Relationship\Trust	5	14
Understanding	Understanding or comprehension of the patients' statements; feeling of also being iunderstood by the patient	Node		Nodes\\Personal Relationship\Understanding	4	8

Codebook WI_1

Name	Description	Node Type	Nickname	Hierarchical Name	Number Of Sources Coded	Number Of Coding References
Acculturation	When people, who are not born or raised in Austria and have immigrated to that country, get used to the system and behaviour of people in that new country here - Austria	Node	Accult	Nodes\\Acculturation	7	14
Age GP	Age of GP is connected to the experiences made by the women immigrants	Node	Age GP	Nodes\\GP attributes\Age GP	5	5
Austrian context	Trait, habits and behavoiural patterns that are seen by immigrants which are not similar to theirs and categorised them as Austrian	Node	neue Heimat	Nodes\\Austrian context	8	30
Communication	Talk between doc and patient	Node		Nodes\\Interaction\Communication	13	84
Communication Strategies	Ways and means immigrants try to communicate with their GPs.	Node		Nodes\\Communication Strategies	12	57
Consultation Differences	Differences in the visit process i.e. from organisational to interaction to treatment regimen at the GP in Austria and in the country of origin or residence prior to coming to Austria	Node		Nodes\\Consultation Differences	12	77
Emotions	Types of feelings that come up before, during and after a consultation	Node		Nodes\\Emotions	0	0
Expectations	What immigrants want and anticipate from their GPs	Node		Nodes\\Expectations	11	35
Experiences with specialists	the encounters made with specialists such as opthalmologist, gynac, dentist etc	Node		Nodes\\Specialists\Experiences with specialists	9	39
Feeling negative	When dissatisfaction appears; unhappy with encounter with GP	Node		Nodes\\Emotions\Feeling negative	7	27
Feeling Neutral	An indifferent and general stance towards the encounters faced with the GP	Node		Nodes\\Emotions\Feeling Neutral	7	11

Name	Description	Node Type	Nickname	Hierarchical Name	Number Of Sources Coded	Number Of Coding References
Feeling Positive	Encouragement, happy, satisfied, empowerment feeling derived from the encounters with the GP	Node		Nodes\\Emotions\Feeling Positive	10	39
Feeling Uncertain	When doubts arise on encounters with the GPs; when the information or situation seems unclear or blurred	Node		Nodes\\Emotions\Feeling Uncertain	9	35
GP attributes	Characteristics the GP is said to have	Node	Character	Nodes\\GP attributes	0	0
GP Consultation	The entire process which entails the organisational part; the encounter with the doctor; the diagnosis and treatment regimen as well as the time taken for the whole consultation	Node		Nodes\\GP Consultation	0	0
GP Procedures	the process during the visit i.e. talk, diagnosis, treatment regimen	Node		Nodes\\GP Consultation\GP Procedures	13	91
Interaction	Talk between immigrants and GPs as well the way the talk with the GP is seen or perceived by the women immigrants	Node	Talk	Nodes\\Interaction	0	0
Language	German or English or other modes of speech used in the conversation with GPs	Node		Nodes\\Interaction\Language	12	61
Listening	When GPs take time and gives undivided attention to what the patient has to say.	Node	Listen	Nodes\\Interaction\Listening	3	5
Migrant attributes	family background, socio economic status, education	Node		Nodes\\Migrant attributes	0	0
Origin	Place of birth or place where immigrants have lived longer before they have moved to Austria	Node		Nodes\\Migrant attributes\Origin	12	43
Personal Connection	This is the degree of famiiarity with the GP	Node	Familiar	Nodes\\Personal Connection	0	0

Name	Description	Node Type	Nickname	Hierarchical Name	Number Of Sources Coded	Number Of Coding References
Personal Rapport	Degree of Professional personal relationship one shares with the GP, feeling of kind of professional relationship women immigrants share.	Node		Nodes\\Personal Connection\Personal Rapport	11	52
Personality	Characteristics, attributes of a person	Node	MigPers	Nodes\\Migrant attributes\Personality	6	13
Personality	How the GP is; how he/she behaves	Node	GP Pers	Nodes\\GP attributes\Personality	9	28
Role	Hierarchical structure between doc and patient, doc and nurses; at the same level - symmetrical or asymmetrical	Node		Nodes\\Personal Connection\Role	6	9
Selection of GP	How GP has been selected, recommendation, family doc of husband's family, proximity etc.	Node		Nodes\\GP attributes\Selection of GP	8	12
Social Security System	Services offered, payments, organisational procedures etc by the Austrian i.e. local social security TGKK	Node		Nodes\\Social Security System	9	50
Specialists	Any other medical doctor besides a GP, a private doc, a specialist	Node		Nodes\\Specialists	5	13
Structural Differences	Differences in the systems between Austria and the rest of the world; differences between the local system TGKK and the various other systems in Austria such as the BVA	Node		Nodes\\Social Security System\Structural Differences	6	9
Time	Duration of the whole consultation process; feeling of time taken by the GP from the viewpoint of the women immigrants	Node	Time	Nodes\\GP Consultation\Time	9	25
Time	Time taken in the visit, check-up, diagnosis, treatment regimen at all specialists	Node		Nodes\\Specialists\Time	3	4

Name	Description	Node Type	Nickname	Hierarchical Name	Number Of Sources Coded	Number Of Coding References
Treatment regimen	all kinds of treatment prescribed or mindset towards treatment	Node		Nodes\\GP Consultation\Treatment regimen	6	9
Trust in specialists	Feeling at ease and comfortable with specialists such as dentists, gynacs etc	Node		Nodes\\Specialists\Trust in specialists	4	5
Trust n Comfort	Feeling of comfort when at the doc - during the interaction, the feeling of belief in the GP and his/her diagnosis, treatment regimen etc	Node		Nodes\\Personal Connection\Trust n Comfort	8	16

Memos WI Interviews

WI_AI_08
She is a graduate student at the MCI. She is studying and working part-time as a cashier in a company. It was easy to contact her and although she is a student and I'm a lecturer, there was no asymmetrical role between us. I had not known her before and do not teach in that program where she is studying so there was no difference among us. A room was reserved at the MCI and the interview took place in a quite area. She was very talkative and at ease and open to answering all questions without much hesitation.

WI_BDL_06
She is a lecturer at the MCI and teaches in the Social Work department. I did not know her and was recommended by a colleague. She was willing to participate and I arranged a meeting at the MCI itself and reserved a room where we could talk in silence. She was friendly and felt at ease but very quite, pensive and contemplative. She needs time to recap, think over and then express her views. It was difficult at the beginning to deal with the silence but I got used to it very fast.

WI_KF_09
She is American and an English lecturer at the Leopold Franzens University. She is a colleague of Emil who suggested her. I contacted her via e-mail who agreed to participate in my interview. I went to her office and we could talk undisturbed. It was a lovely atmosphere with coffee, tea and cookies that she had prepared , so we had a nice informal conversation. She was friendly and very expressive in her views and opinions.

WI_LC_10
She comes from Kenya and a former student of MCI . She did her post fraduation in Management Communication and IT. She just finished her studies and in now expecting her first baby. I knew her vaguely as I had assisted her in the application process for a scholarship. I asked her if she would like to participate via e-mail and as she was willing to contribute, I arranged a room at the MCI, where we had a nice quite chat. She was very informative and open in answering all questions.

WI_PGN_13
She was recommended by one of the former respondents. She is Brazilian and has Austrian roots. She is married to a German and lives in Austria. She came here to see the part of her roots and decided to settle down here. I interviewed her in the evening after work at her residence. It was a nice, friendly working atmosphere, where she answered the questions openly.

Memos GP Interviews

GP_AHK_04
He is a friend of a colleague of mine at work. He has his practice in Schwaz which is about 20 kms from Innsbruck and is the next biggest city in the state of Tirol. There is a high migration population in this city. He gave me his interview at the end of his morning practice. It was a nice long interview with slight disturbances (telephones ringing) but he was extermely communicative and engaged in conversation. It was a very friendly and informal atmosphere too

GP_CO_06
He is a young GP working with two other female doctors in their practice. His practice is in Mühlau which is a part of Innsbruck and not too far from the main city. He was willing to give an interview and it took place after his morning appointments i.e. around noon. He took time in reflecting and answering the questions. There was no rush into thing. He was communicative and factual in stating his experiences. It was a good conversation.

GP_AW_07
He is a GP and also the president of the Chamber of Medical Doctors in the Tirol. I also sent him an e-mail requesting for participation and he willingly agreed to it. We meet in the Chamber of Medical Doctors in his office and after his working hours so we could chat undisturbed.
He was very reflective and in detail as regards his views and experiences. It was a friendly working atmosphere.

GP_CR_08
I sent him an e-mail requesting for participation in my research study. He willingly agreed and we met at his dispensary in the evening after his working hours. This was the longest ever interview I had had. It lasted more than an hour. He was extremely delighted to share his views and he did so in utmost detail. He was very communicative and gave detailed background information well associated and connected to his experiences. He was also a bit politically oriented which one heard in a subtle manner. With the exception of a disturbance occured through a telephone call, all went well and well elaborated.

GP_MW_10
I also contacted her via e-mail asking her if she would like to participate in my research. She agreed. I set an appointment and went and met her at her dispensary. I had to wait quite a while as she had plenty of patients and finally we could chat alone without any disturbance. She was communicative but emotionally restrainted. Very to the point and just answering the questions was the most important aspect. It so coincidentally happened that we found that we had friends in common but this we figured out at the end of the interview, maybe it would have worked much better had we known that at the beginning of the interview.

Reflective Journal

Initial Stages

What triggered me to research on this topic?

First of all I did my post-graduation in translation and then did a post-graduate diploma in Business Management, I continued with certificate courses in the field of intercultural communicaiton. This has to do with my profession as a lecturer and as the Associate Head of International Relations in a Business school in Austria. My tasks involve teaching Business English, Intercultural Commmunication at the undergraduate and graduate level. Moreover, my task in the International Relations Office demands working with partners all over the globe, which strengthened my interest in the field of intercultural communication even further. Furthermore, my personal background - being an immigrant myself deepens the desire to highlight issues that bother us immigrants and hope for better services or quality of care which in turn is effective and beneficial to all.

Why in the field of healthcare?

I have been teaching in this programme since its inception 12 years ago at the undergraduate and at the graduate level. My personal interest in health issues as well aroused my curiosity in this field. I did some initial research and realised that there have been studies carried out in Austria but they are ethinicity or nationality oriented. Studies on a diverse population were not found so that made me focus more on this aspect. As I'm personally convinced and am fully in line with Adrian Hollidays concept of small culture ; I wanted to connect the two and design my research.

Another reason is that the healthcare system is fantastic in Austria and I believe there is room for improvement and the situation for immigrants can be made better; this will help all stakeholders involved, the patients, doctors as well as those responsible at the structural level. My research may provide an impetus for awareness and perhaps some action. It can contribute to the wellbeing of immigrants.

Where and how culture influence the encounter?

The essentialistic way of describing culture i.e. through nationality was something I was not fully convnced of although this is taught very often in classes and trainings etc. I am very well aware of this position but was never fully convinced of it. I accept it to some extent. My assumptions were in line with Adrian Holliday's theory as I could personally relate to it. I was then curious to know how and to what extent culture played a role in the Austrian context and was surprised to see the themes that emerged in my research findings and how culture shapes these themes so to say. I was surprised to see the ways culture influenced the communication and this gave me an even clearer picture of my clinical encounters.

Starting with reading up on theory initially took me into circles. I did not know how to categorise the works I had read; so I decided to take tips from experienced researchers who showed me to summarise the work I read into several categories in an excel sheet.

Over the years I have followed this process. I then read through dissertations in this field which gave me an idea of how the literature review was conceptualised. Next I worked on mine.

During the Interview

With the immigrants it was not difficult at all. I gelled very well with them; it was always informal and they were conducted in English. Starting from the venue, seating arrangement to the small talk everything went off smoothly.

Conducting interviews in German was a challenge for me. The interivew guide was in German. I did not want to look constantly into it. So I rehearsed the questions before hand. Formulating the probing questions spontaneously was a challenge. I wanted to sound professional and cover my anxiety , wanted to look like a mature researcher. I also rehearsed the probing questions in my mind which distracted me at times from the information given. I also had to see that all questions were asked in a limited time period as the GPs were restricted in time. It was quite a balancing act to appear confident and calm so that the participants could put their trust in me and be open in sharing their experiences or accounts.

After Interviewing

The following themes will be coded: the Austrian situation, the healthcare system, the differences seen in the structural system, the communication between the GP and the women immigrants, the specialists .

The themes under specialist will be coded however excluded from the analysis.

Coding Process

01 May 2018

with the help of the list view i had a look at all the nodes then I thought of creating a hierarchical coding for the nodes feeling negative, positive, neutral and uncertainity - with the main node - Emotions; next I am thinking of merging communication and interaction into one node - Interaction;

general strategies and communication strategies will also be merged into one or with the hiarchical system termed stratgies and then the two sub nodes general and communication

Before this is done I will read through all the extracts of data in each node to see if they make sense, if they need surrounding data and if they are assigned to the appropriate note before i decide to print the codebook

02 May 2018
I sorted some extracts where I copied them and pasted them in other codes I found more appropriate ; I deleted the code challenges as it was redundant; as well as code general strategies as the extracts from this code were merged into communication strategies; The node GP attibutes am not sure if attributes is the right generic term, however, two sub codes time and treatment regimen that were there are now moved as sub codes in the node GP procedures; the nodes illness and legal implications which had only two extracts of data each were also deleted. The legal implications is not directly related to this topic and illness contained a one-liner statement on the illnesses she had and went for treatment; hence deleted
the two extracts from GP in rural areas could also be merged into the subcode time and role. thus this code was also deleted; same applies to GP in urban areas, this code was redundant as there has been no extract or comparison between rural and urban etc. the values sub code was also deleted
the code security was also deleted and its extracts merged into trust and comfort

16 May 2018
attitude towards GP was deleted. The extracts of the data were assigned to other existing codes; likewise the experiences with GPs will be deleted and the extracts will be merged into existing codes. With the help of the tutorials on Youtube I then watched the tutorials and created a codebook with the final codes used. I also created an overall chart on the various themes that emerged as well as hiearchical charts on the codes that had sub codes.

21 May 2018
Hierarchical charts were drawn as well as graphics on each code that has subcodes. A holistic chart of the coding map was also created and the interactional cycle of this group was also graphically depicted. The latter two were created in a power point.

Next the comparison between the two and the analyses will be carried out in the findings chapter.

09 Jan 2019
When i reported the findings i clustered the codes that emerged in to common themes and independent themes. Thus, I had to reshuffle and create new codes n sub codes to bring about clarity and consistency in my work. I created a code called communication dimensions which contained the sub codes personal connection and communication strategies and interaction. Personal connection and interaction were main codes now subsumed to the code communicaiton dimension. The code communication strategy which was initially a sub code of interaction is now a sub code too of communication dimensions and not a further subordinate code.
Consultation Context was the new code created with sub code consultation differences and the GP consultation with its sub codes treatment regimen, time, and procedures.
I also added the code Austrian context as a sub code to the Social Security System as there is quite a overlap about the structural aspect of the system and the Austrian society in general.

Iterative Process

After the findings and the themes that had emerged I had to go back to the lit review and read again certain aspects of culture - the essentialist part; the relational aspect in clinical communication, role of the GP in order to alter my literature review such that the material that was challenged be critically read and addressed.

Impact on me

The findings made me actually recap on my experiences and I could understand why I subconsciously or consciously choose my GPs or react in consultations and strategies that I employ in conveying my message to the GPs or other specialists. This was an interesting journey of intropection for me. This helped me probe my thinking at a deeper level and look for associations instead of descriptions. I feel the research enabled me to seek a detailed in-depth understanding of the associations and not just exploring the surface of participants' experiences.

"Me too moments" came up as I recognised similarities between me and my women immigrants phenomenon. This made me dig deeper and it enhanced my self awareness as well as of the others helping me to develop a greater insight into both.

While I was writing my discussion chapter I realised when I was citing my participants the issues I went through too during my GP visits.
Like most of the women immigrants me too went to the GP who was a friend of my then partner. He was a young guy our age and it was nice as he knew my then -partner well. They were friends from teenage days. A competent man who indulged into general conversation when he had the time or when he was in the mood so to say. Otherwise, it was business as usual. I did not ask much questions back then as was not used to it and took every advice I was given at face value. The treatment prescribed proved effective so I trusted him.

After about a decade I changed my GP and here again i chose someone who I had got to know over the years. She was good too and effective in her diagnosis. I realised while reading through the citations that i had intentionally decided for a GP who I knew personally as the personal relation to the doctor matters a lot to me. I realised also the all the specialists I have been to so far were either recommedations from friends or friends to whom I have been.
The conversation is different when you know the person. I get the feeling that their approach is different; they pay more attention to you and your requirements. Moreover, I feel more comfortable and at ease with them. In cases where the doctors are not known to me and it is a one-off visit or once a year visit, am aware that you have to be straight to the point and that has never bothered me. In fact I am not interested in making any kind of small talk with them, but in the case of a GP, I do feel it is important.

My GP retired and I now have new one, who is very professional and task-oriented. I found that the physical was not optimal or let's say up to the standard I am used to, so I have decided to change the GP and have been asking around. I know I will go to one with whom I can establish a rapport and this gets easier when they are friends of colleagues or friends.

I'm not sure if it is a age factor or maturity but over the years I have become more health conscious and do ask questions about the meds prescribed, look for alternative ways of solving my issues; am an active patient who wants to know more about her illness, which perhaps is a bit irritating for GPs who are facing time restrictions.

On the other hand, after having interviewed the GPs I do understand the pressure they face. Constantly battling with various language barriers and time limits; checking 80 - 100 patients a day at times is certainly strenuous. Small talk or breaking the ice is something that is not part of the clinical culture here is Austria. With the exception of two specialists and my GP two GPs I have in general never experienced it. It has always been task-related. YOu walk in and tell them what's wrong, they advice you and you walk out. I also realised that basic checks were not done at every visit irrespective of the illness, some thing I missed here as this was a general routine in India. I guess they do it here only when they feel it is essential or connected to the illness - such as bad cough or congestion or ear ache etc.

As I was citing the themes I realised that I had gone through the same issues and my communication strategy was to ask around before I choose the doctor; tell them during the consultation through which contact i had come there in order to break the ice and create a rapprot; ask questions a few at least during the consultation; sometimes I have called them and asked further questions if I was unclear or uncertain about something. The fact that you are a "familiar person" so to say through the connection has made them more open and willing to answer.

I think the GPs are in general very nice and friendly and open to answer your queries so long as it is not too time consuming. One has to be precise in asking the questions. Language - the dialect was initially an issue but not anymore for me. I understand them well now.
I must say when the doctors realise that you speak the language - perhaps not their dialect but the German language they are very impressed for one and very accommodating too in nature. These are the experiences I have made so far.

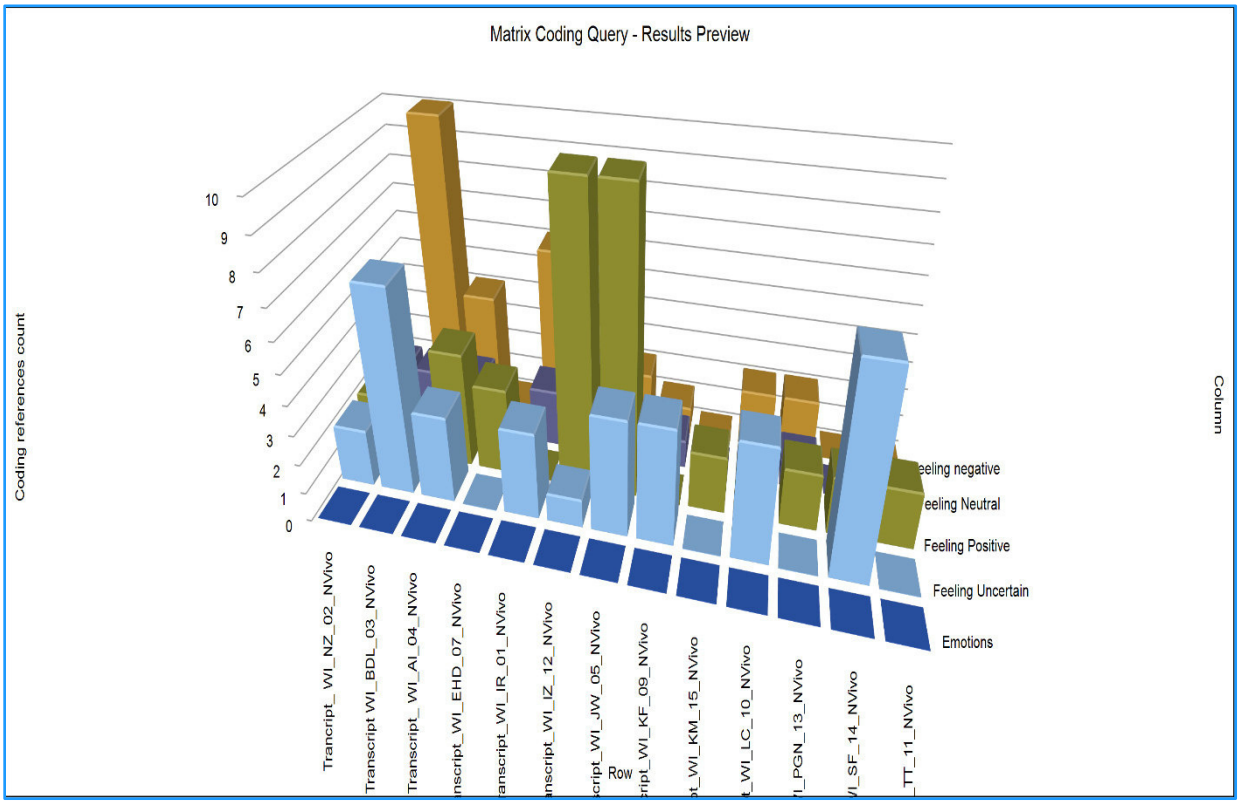
Writing up my work

It has been hard work with long nights and weekends but exciting most of the time. Have now complied everything and the work ha staken good shape or Gestalt as one would say. I enjoyed every bit of it. I got carried away with writing and exceeded terribly the number of prescribed words. My task now was to cut down 13,500 words. It took me two weeks to do so. Then I had to work on the formatting and the cross referencing, checking it and re-checking it. The frustrating part of it is that one still finds a comma or a typo error – no matter how often you read it. I have reached the stage that I cannot see the mistakes any more – in German one would say Betriebsblind. All in all it has been a wonderful journey with ups and downs.

Matrix Query Table Excerpt-GP

	A : Transcription_GP_CR_08_NV	Transkription _GP_UG_02_NV	Transkription_GP_AHK_04_NV	Transkription_GP_AW_07_NV	Transkription_GP_CO_06_NV	Transkription_GP_GQ_09_NV	Transkription_GP_MW_05_NV	Transkription_GP_MW_10_NV
1 : Patients	0%	0%	0%	0%	0%	0%	0%	0%
2 : Patient Personality	5,45%	0,39%	0%	0%	0%	2,91%	2,92%	1,1%
3 : Illness perception	4,49%	2,13%	5,13%	11,12%	6,33%	8,89%	0%	9,4%
4 : Gender	13,1%	0%	0%	0%	0%	0%	0%	1,99%
5 : Ethnicity-Nationality	11,7%	24,95%	30,91%	22,69%	15,26%	9,7%	22,32%	17,91%
6 : Acculturation	0%	0%	0%	0%	0%	3,49%	0%	0%
7 : Migration	0,86%	0%	0%	0%	0%	0%	0%	8,69%
8 : Interaction	0%	0%	0%	0%	0%	0%	0%	0%
9 : Communication Strategies of GPs	16,01%	13,99%	9,7%	18,83%	31,76%	24,64%	22,14%	8,33%
10 : GP Consultation Procedure	31,96%	32,95%	19,77%	22,96%	27,71%	25,18%	23,21%	16,67%
11 : GP Constraints	0%	0%	0%	0%	0%	0%	0%	0%
12 : Treatment regimen	1,6%	4,96%	1,24%	5,01%	9,68%	7,57%	0%	8,3%
13 : Time	1,74%	4,71%	0,92%	0,99%	0%	1,9%	0%	4,45%
14 : Role	2,63%	0%	1,13%	0%	0%	0,66%	3,37%	2,24%
15 : Patients' Education	6,75%	1,48%	1,74%	0%	0%	2,56%	0%	8,01%
16 : Fear and Anxiety	1,05%	10,83%	6,1%	0%	0%	6,83%	0%	0%
17 : Communication Barriers	0,81%	0%	1,74%	5,72%	0%	0%	1,33%	3,03%
18 : Translator	1,51%	3,61%	14,64%	0%	4,96%	3,03%	4,34%	3,56%
19 : Language Barriers	0,33%	0%	6,99%	12,67%	4,3%	2,64%	20,37%	6,3%

Matrix Coding Query Women Immigrants - Emotions



Matrix Coding Query General Practitioners – Personal Connection