Experiences of International Medical Graduates Caring for Type 2 Diabetes Patients in Saudi Arabia: Perspectives of Physicians and Patients

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Abstract

Background

Around 80% of the physicians working in Saudi Arabia providing primary health care are international medical graduates from other countries. They may not share their patients' cultural background or language, yet are expected to deal with local patients with chronic health conditions, such as type 2 diabetes mellitus, who need culturally sensitive lifestyle advice.

Study aim

To explore and understand challenges and facilitators to effective communication between international medical graduates and patients with type 2 diabetes mellitus and how this may influence care provision in Saudi Arabia.

Methods

Data were collected in three phases: i) A focus group discussion with 6 international medical graduates from one hospital and 13 semi-structured interviews with international medical graduates from the hospital as well as 8 primary health care centres. ii) Semi-structured interviews with 16 Saudi patients with type 2 diabetes mellitus and iii) follow-up interviews with 5 international medical graduates. Data were analyzed with the aid of NVivo using thematic analysis.

Findings

Most of the international medical graduate participants reported that dealing with local patients was challenging because patients did not trust them for culturally-related reasons. Prejudice among local patients towards international medical graduates was identified, and this contributed to patients not acknowledging international medical graduates' ability to provide culturally sensitive advice. Furthermore, some international medical graduates had a stereotypical view of local patients, which had led to an inflexible approach when advising patients. Both groups of participants identified contrasting expectations regarding relationship-building style. Participants also identified self-adopted strategies to overcome communication barriers and suggested new ones.

Conclusion

Findings suggest that efforts need to be targeted towards changing patient attitudes, as well as addressing the training needs of international medical graduates, in order to enhance the effectiveness of diabetes management and improve overall the delivery of health care in Saudi Arabia.

List of Abbreviations

CDM	Cultural development model
CDUT	Cultural diversity and universality theory
GP	General practitioner
IDF	International Diabetes Federation
IMG	International medical graduate
KKUH	King Khalid University Hospital
MOH	The Ministry of Health
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PHCC	Primary health care centre
PMCC	Purnell model for cultural competence
QoL	Quality of life
RCT	Randomised controlled trials
SA	Saudi Arabia
SCHS	Saudi Commission for Health Specialisties
SDM	Shared decision making
SLE	Saudi Licensing Exam
T1DM	Type I diabetes mellitus
T2DM	Type II diabetes mellitus
UK	United Kingdom
US	United States
WHO	World Health Organization

Table of Contents

List of Tables

List of Figures

Preface

In 2008 I graduated from medical school in Riyadh, Saudi Arabia (SA). During the internship year, I chose to spend two months of training in the Family Medicine specialty at the University hospital, although it was not one of the obligatory rotations that interns were required to do. Throughout that period, I was expected to run a clinic, under the supervision of one of the academic staff who was a family physician.

During that period, I was often asked by international medical graduates (IMGs) to leave my clinic and help them to communicate with the Saudi patients. I was translating and interpreting information between IMGs and patients and sometimes educating patients about their health condition; teaching the IMGs about what was acceptable to do and say to Saudi people and what was not; and writing down some Arabic words for them to memorize. As interpreting services were not available for physicians and patients in this University hospital, and IMGs are not required to speak the Arabic language in order to work in SA, I wondered how IMGs run their clinics when no one is available to assist them.

I undertook my Master's degree in Sheffield thus, was myself an "international" student. However in my case, the university supported me both academically, by providing academic writing and reading courses free of charge and non-academically, by assigning a personal tutor to assist me with non-academic issues. Additionally, I attended weekly activities that were arranged by the university to help students to interact with other students and get to know the culture. Because the university I attended in the UK recognized the value of developing students' language competence and cultural

knowledge, and provided opportunities for this, I was easily able to complete the purpose of my visit to the UK successfully.

Similarly empowering services are not available to "international" physicians in SA and this fact may influence the purpose of their visit, which includes providing care for local people. A specific interest arose as I recognized that exploring IMGs' experiences in caring for local patients is an under-researched area.

Introduction

This thesis concerns the exploration of the experiences of IMGs and patients with type 2 diabetes mellitus (T2DM) from one hospital and eight community-based primary health care centres (PHCCs) in Saudi Arabia (SA), using qualitative interviews.

This thesis comprises seven chapters:

Chapter 1: Describes the background of the topic. It introduces the Kingdom of SA where the study was conducted. It gives an overview of the Saudi Arabian health care system and provides background information on the status of IMGs in the country.

Chapter 2: Presents an overview of the evolution of cultural competence in health care. It highlights the history, discusses definitions and presents the key developmental stages of the models of cultural competence. Additionally, it shows the differences between cultural competence and patient-centred care models of communication.

Chapter 3: Critically reviews the research on the effectiveness of cultural competence training on quality of care. This is followed by a review of the literature focusing on IMGs' and local patients' experiences and presents the challenges, already identified, as well as facilitators, to effective cross-cultural communication. The final section focuses on Saudi-based research regarding cross-cultural care.

Chapter 4: This chapter presents the study rationale and outlines the key points from the literature review, which helped to focus the current research. It then articulates the research aims and objectives.

Chapter 5: Describes the methodology of the study. It discusses the rationale for using a qualitative methodology for this type of research and the reasoning behind employing focus group and semi-structured interviews as the method of data collection. It recognises anticipated and encountered ethical issues related to this study. The chapter then presents the methods used, including the settings, sampling strategy, sample profile, recruitment, research encounters and discussion of the process of collecting the data. Data analysis is described including the challenges to managing the data and writing them up. The final section of this chapter evaluates the quality of the qualitative study.

Chapter 6: Explores, in detail, the key findings of the study. This chapter includes three sections, each of which explores a different theme. The first section discusses the relationships between IMGs and local patients and the effect of these on care provision. The second section presents the effect of IMG-patient cultural discordance on IMGs' ability to provide culturally sensitive lifestyle advice. The third section presents strategies used and proposed by IMGs and local patients to facilitate cross-cultural communication.

Chapter 7: In the Discussion chapter, a brief recap of the study is presented in the first section. In the second section, key findings are presented and then situated in terms of the related, relevant literature. The ways in which this study coheres and contrasts with previous research and how it contributes new insights are presented and discussed. The third section evaluates the strengths and limitations of this study before it considers its implications for policy and practice and priorities for future research. The final section forms the conclusion of the thesis.

Chapter 1

Background

1.0 Introduction

This chapter describes the context of the Kingdom of Saudi Arabia (SA). This is followed by an overview of the lifestyle of Saudi people, with regards to dietary customs, physical exercise and alternative medicine. It then highlights key information about type 2 diabetes mellitus (T2DM) and finally, it offers an overview of the Saudi Arabian health care system and provides background information on the status of international medical graduates (IMGs) in the country.

1.1 The Kingdom of Saudi Arabia

The Kingdom of Saudi Arabia (SA) is located on the Arabian Peninsula, in the southwest of the continent of Asia. It occupies 2.15 million square kilometres and its estimated population is 29 million inhabitants (MOH, 2012). The Riyadh region - in which Riyadh city, the capital of SA, is located - has a population of around 7 million, of whom 68% are Saudi nationals (MOH, 2012).

SA shares borders with Kuwait Iraq and Jordan to the north, the Sultanate of Oman and Yemen to the south, Bahrain, Qatar and the United Arab Emirates and the Arabian Gulf to the east, and the Red Sea to the west (Figure 1.1).

Figure 1.1 Map of the Kingdom of Saudi Arabia

Due to its different geographical terrains and the influence of high tropical air, the climate in SA varies from one region to another. Generally, however, it has a very hot summer ($> 50^0 C$) a cold winter ($10^0 C$) and the northern and southern regions are rainy in winter. Some outsiders see SA as the source of oil and the land of wealth. Others link it to the desert, extreme heat and camels, while to many it means the birthplace of Islam. All Saudi citizens are Muslims; however, as in any other part of the world, the degree of practice varies from conservative, traditionalist or liberal. Nowadays, SA has become well known as the largest oil producer and exporter. It has experienced rapid socio-economic development since the discovery of oil, which constitutes the major portion of the country's revenues.

Oil wealth has allowed SA to provide free health services, education and a tax-free society to its residents.

1.2 An overview of the general lifestyle among Saudi people

1.2.1 Dietary customs

Saudi people tend to have a traditional approach to their diet and prefer to eat certain foods. Some of the traditional Saudi foods that are commonly consumed are "Kabsa" and dates.

"Kabsa" is a rice dish that is usually cooked with red meat and sometimes with poultry. The main meal of the day in SA is lunch, and it usually includes "Kabsa", which is rich in carbohydrates and fats. In addition to "Kabsa", dates have a special place among Saudis. The date has a religious value as well as cultural importance because it was mentioned in the Quraan; and Prophet Mohammad's teachings encourage the consumption of dates. The palm tree is referred to in the Quraan as "the blessed tree" and the Prophet Mohammad,

whose sayings and actions most Muslims try to follow as much as possible, advocated eating seven dates early in the morning. Additionally, date farming was the dominant sector of the Saudi economy before the oil industry. Therefore, the Palm tree is the national symbol of SA. There are many types of dates. They are rich in carbohydrates, sugar and high in calories. Dates are served with honey, caramel and chocolate, which can add to their richness and glycaemic index. Due to the small sizes of dates, they are usually served in large numbers. A tradition followed by almost all families in each Saudi house, is to gather for Arabic coffee and dates after sunset.

Younger Saudi generations have adopted a non-traditional lifestyle which is characterised by unhealthy dietary patterns (Midhet et al., 2010). This is supported by the spread of fast food restaurants, especially in urban areas. However, traditional dietary habits are also still prevalent among young people.

The main recreational activities in SA involve formal and informal socialising. The concept of hospitality is very important, and revolves around offering food to guests. Offering a meal that does not involve rice and meat is considered impolite. Furthermore, it is not considered polite for guests to refuse food offered by the host.

All of these cultures and traditions around food can make it difficult for people to control their diet, therefore leading to a high prevalence in the country of chronic conditions such as type 2 diabetes mellitus (T2DM).

1.2.2 Physical exercise

The climate in SA is extremely hot, and in summer it can reach more than $50^0 C$. Because of this weather, coupled with a lack of paths and pavements for pedestrians, and a high usage of cars, it is rare to see people walking outdoors.

Saudi Arabia has many gymnasiums, but it is not considered culturally acceptable to see people over 40 years of age using them and they are mainly occupied by people from younger generations. Some families do not allow females to join the gymnasiums and many families do not allow them to walk outdoors. Therefore, middle aged, older people and females are restricted in terms of being physically active.

A national survey showed that 96%, of the 17395 male and female respondents aged 30-70 years, have inactive lifestyles (Al-Nozha et al., 2007). An inactive lifestyle in this study was based on less than 30 minutes of moderate-intensity physical activity fewer than three times a week. This kind of lifestyle was the most common in the central region of Riyadh and the least common in the southern region (Al-Nozha et al., 2007). This is likely to be because Riyadh is much more urbanised than the Southern region in which there are a lot of people who work as farmers and shepherds and have more active lifestyles (Al-Nozha et al., 2007).

In short, the living environment, habits and customs, in addition to a more modern lifestyle in SA can encourage people to have sedentary lifestyles (Al-Hazzaa, 2004), again leading to a prevalence of chronic conditions such as T2DM.

1.2.3 Alternative medicine

The use of alternative medicine is common among Saudi people (Al-Faris et al., 2008). Alternative medicine using cumin, honey and black seeds was acknowledged more than 1400 years as its use was mentioned in the Prophet Mohammad's teachings. Saudi people refer to this type of medicine as "Prophetic medicine".

Alternative medicine in Islam includes practices such as cauterization, cupping, reading the Quraan and repeating certain sayings pointing at a painful area. All these practices are commonly used by Saudi people (Al-Rowais et al., 2010).

Although alternative medicine may include the use of herbal medicine, the term "herbal medicine" is used among Saudi people to refer to herbs and spices that are used as medicine, yet were not specifically recommended by Islamic teachings. For example, myrrh, helteet (Asafoetida) and fenugreek are some of the herbs used specifically by Saudi patients with diabetes (Al-Rowais, 2002).

Saudi people strongly believe in alternative medicine, in general, probably because it is recommended in Islam; however, unhealthy practices in this regard are not uncommon. For example, a study showed that Saudi patients may abstain from using prescribed medical treatment when they use herbs to treat chronic disease such as T2DM (Al-Rowais, 2002).

In SA, "Attar" shops, which sell a huge variety of herbs, are found in abundance and the sellers are usually older, traditional Saudis who pass their experience on to their children and are consulted by the consumers regarding herbal remedies for certain health conditions. Seventy-three percent of the 296 patients who were included in a study to determine the prevalence of herbal medicine use among patients with diabetes, did not inform their physicians in regard to using herbal remedies to treat diabetes in SA (Al-Rowais, 2002). Patients' reasons for not informing their physicians included the fact that doctors did not ask questions that related to the use of herbs, they did not think it was important for doctors to know, or they feared that the doctor would ask them to discontinue taking it (Al-Rowais, 2002).

Due to the extensive use of alternative medicine, the Saudi Council of Ministers issued a resolution in 2008 for the National Center for Complementary and Alternative Medicine to be created as a pioneer in regulating and controlling practices of complementary and alternative medicine under the Ministry of Health (MOH). In 2013 the Health Minister

announced that the need to support alternative medicine with scientific experience had become urgent due to the recognition of the growing use of alternative medicine and regulate the use of this kind of medicine as it may affect patients' consumption of prescribed medication.

In general, the previously identified genetic predisposition to developing diabetes among the Saudi population, which is complicated by the tradition of consanguineous marriages (El-Hazmi et al., 1995) that contribute in increasing the risk of developing T2DM (Anokute, 1992, Bener et al., 2005) and the high obesity rate that resulted from the above mentioned unhealthy lifestyle, have led to the increased prevalence of T2DM in the country (Elhadd et al., 2006).

1.3 Diabetes and its management

Diabetes is a major public health concern across the world. It has devastating complications and implications in terms of patients' health (Weinger and Leighton, 2009). Globally, the estimated number of people with diabetes is 285 million in 2010, and it is expected that it will affect 366 million people by the year 2030 (Wild et al., 2004).

1.3.1 Type 2 diabetes

Diabetes represents a group of metabolic defects characterized by increasing blood glucose concentration (hyperglycaemia) resulting from a decrease in insulin secretion, action or both (insulin is the key hormone controlling glucose flow in and out of the body cells) (Watkins, 2003). Type 1 diabetes mellitus (T1DM) is the most common type affecting children and young people. It is also known as insulin dependent diabetes

mellitus (IDDM) because patients mainly rely on insulin to control their condition. Type 2 diabetes mellitus is the most common type affecting adults. This type was previously known as non-insulin dependent diabetes mellitus (NIDDM), as giving insulin is not the first or only solution to control the condition. Furthermore, lifestyle behaviours such as unhealthy eating habits and adopting sedentary lifestyle are key factors for developing T2DM. The table below summarizes the main differences and characteristics of T1DM and T2DM.

Table 1.1 Different characteristics of type 1 and type 2 diabetes mellitus (Watkins, 2003)

Type 1	Type 2
Cause	
Loss of insulin production	Decrease insulin secretion, increase insulin resistance, or both
Incidence	
Peak incidence at 10-12 years of age. 70% of the cases occur <40 years of age. Has slightly male predominance	Most commonly affects people between the ages of 50 – 70 years. Children from certain ethnic groups might present with T2DM, especially if combined with obesity. Equally effecting males and females
Risk factors	
Genetic Environmental Autoimmune destruction of the pancreas	Obesity. Age of more than 40 years. Certain ethnic groups (Afro-Caribbean, Asian, Hispanic). Family history of diabetes. History of gestational diabetes
Treatment	
Insulin in conjunction with diet and exercise	In sequential order: Diet and exercise Oral hypoglycaemic agents

1.3.2 Burden of type 2 diabetes

The mortality risk in people with diabetes is doubled compared to their non-diabetic peers (WHO, 2011). Complications of diabetes include: retinopathy, which can lead to blindness in people of working age (Melville et al., 2000); nephropathy "kidney disease", which is found 17 times more in diabetics, compared to non-diabetic people (Amos et al., 1997); coronary heart disease, which is two to four times higher; stroke, which has a two fold increase among diabetics compared to non-diabetics (Beul, 1994, Morrish et al., 2001); peripheral vascular disease, which causes more than half of non-traumatic lower limb amputations as a complication of diabetes (ADA, 2003); and neuropathy "nerve damage", which affects up to 50% of people with diabetes (WHO, 2011).

Furthermore, T2DM causes a heavy direct economic burden on health services and indirect burden by limiting the productivity of patients of working age (Hex et al., 2012).

1.3.3 Type 2 diabetes management

Achieving quality of life (QoL) and life expectancy similar to that of the general population is the main goal of managing T2DM (DiabetesUK, 2005). This can be achieved by controlling blood glucose levels to prevent the development of diabetes related complications. Control, in this context, indicates preventing blood glucose levels from getting too high (hyperglycaemia) or too low (hypoglycaemia). Average glycaemia control is assessed by haemoglobin A1c (HbA1c) which gives average glycaemia over a period of two to three months (NICE, 2009). The recommended target HbA1c, according to the National Institute for Health and Care Excellence (NICE), is between 6.5%-7.5% (NHS, 2009).

NICE recommends management of T2DM based on planned steps that start with non-pharmacological management including changing lifestyle behaviours by improving dietary habits and getting physically active (NICE, 2009). If T2DM patients fail to control their blood glucose levels by lifestyle modification, there is a shift to the second step, which comprises adding oral hypoglycaemic agents to the treatment plan. If the second step shows limited control over patients' blood glucose level, insulin can be added to the plan (NICE, 2009).

As T2DM entails behavioural and lifestyle modifications, it is widely understood that diabetes self-management is crucial (Heisler et al., 2002). However, there is evidence to suggest that technical knowledge of the physician, combined with personal preferences of the patient, should work together to produce an effective management plan (Olivarius et al., 2001, Anderson et al., 1995, Von Korff et al., 1997).

1.3.4 Caring for patients with diabetes

Diabetes is one of the chronic conditions that require significant lifestyle changes in order to be managed successfully. Patients are expected to incorporate diabetes and its management plan into their lives in order to achieve good diabetes control.

The role of health care providers in continuously educating and promoting self-management, improving patients' QoL and making a treatment plan based on mutual understanding and shared decision-making, is very important when managing diabetes (Heisler et al., 2002, Aikens et al., 2005, Gadsby, 2003). Setting an effective management plan for T2DM patients based on shared decision-making requires good physician-patient communication. For the above reasons, patient-physician communication is particularly important in T2DM as it requires the patient not only to

understand, but also to be properly educated and motivated by their physicians to follow the advice they provide.

Health care studies are giving increasing attention to patient-physician communication (Heisler et al., 2002, Stewart, 2001). Effective delivery of health care can be limited by difficulties in communication between patients and health care teams, in general, and physicians, in particular. Patients with chronic conditions, such as diabetes, are long-term clients who have recurrent needs. Their condition requires them to understand its risk factors, be involved in their treatment plan, and recognize their own role in managing it. Evidence suggests that part of the reason why many diabetes patients are not following an optimum management regime can be attributed to the patient-physician relationship (Heisler et al., 2002). Furthermore, The World Health Organisation (WHO) has long supported the right of both patients and their physicians to participate in health care delivery (WHO, 1987). Applying this requires good communication between patients and their physicians.

1.3.5 Prevalence of diabetes in Saudi Arabia

Diabetes in SA is reaching epidemic proportions. The prevalence of diabetes in this country is one of the highest in the world (IDF, 2009). In 2004, an extensive national survey revealed that almost 24% of the Saudi population between the ages of 30 and 70 suffer from diabetes (Al-Nozha et al., 2004) and the prevalence of this condition is increasing. At the same time, the prevalence of poor control of the condition is also increasing (Al-Baghli et al., 2010, Azab, 2001, Abu-Zeid and Al-Kassab, 1992), prevalence of diabetes complications are rising, and multiple complications are frequent (Alwakeel et al., 2008). As a result of the previously mentioned lifestyle characteristics

among Saudis, coupled with culture-based constraints, including social etiquette, people's negative views on females and older people exercising, and the extremely hot weather that restricts outdoor activities, this high prevalence of T2DM is to be expected.

1.4 An overview of the health care system in Saudi Arabia

The Saudi government is currently giving a high priority to health care services. Special attention is being given to primary health care services, as one of the MOH's key aims is to decrease the load on hospitals and focus on promoting health and preventing diseases. At present, the MOH is the main provider of health care services in the country, and their main source of finance. Under the MOH there are 259 hospitals with 35,828 beds and 2,259 primary health care centres (PHCCs), which are distributed over the country. The Riyadh region has the largest number of PHCCs (MOH, 2012). Furthermore, the private sector, which also provides all levels of health care and health programmes, is supervised by the MOH, which in addition manages, plans and formulates health policies (Al-Yousuf et al., 2002).

PHCCs are the network through which primary health care services are delivered in SA. They are equivalent to general practices in the UK. The numbers of PHCCs are dramatically increasing as a result of the increasing demands of the population (MOH, 2012). Most of these PHCCs are located in the main cities such as Riyadh, Jeddah and Dammam. Each PHCC provides health care services to a defined population within its catchment area (Al-Yousuf et al., 2002).

The total expenditure allocated for the health sector has been increased over recent years by the Saudi government. It increased from 5.6% of the total national budget in 2008 to 6.2% in 2009 and more than 6.5% in 2012 (MOH, 2012). Full and free access to all

healthcare services is provided to citizens and expatriates working within the public sector (Aldossary et al., 2008).

Other autonomous agencies provide and finance health care services for national citizens, such as university hospitals, which are operated by the Ministry of Higher Education, or for employees and their families, such as military hospitals, which are operated by the Ministry of Defense and Aviation (Al-Yousuf et al., 2002). The military hospitals in SA are reputed to have high standards and are operated by staff who hold qualifications from developed countries such as the UK, the US and Australia.

The referral system in SA is theoretically similar to that of the National Health Service (NHS) in the UK. Under the Saudi health system, patients first present their symptoms to the General Practitioners (GPs) who are assigned to the community-based PHCCs found around the country (MOH, 2012). Referrals to secondary health care, or to general hospitals, take place if complications are suspected by the GP. Family physicians assigned to hospital-based primary health care clinics will then assess patients and refer them to a specialist if their condition requires that, or send them back to the community-based PHCCs. If the hospital-based specialist controls a patient's condition, they will be sent back to their community-based GP for follow-up. However, tertiary care will be sought if a patient's condition requires higher specialized care, such as an organ transplant (Almalki et al., 2011).

The high level of attention and generous expenditure on the part of the government, along with the plans of the MOH to improve its health care system, have made the Saudi system comparable to some of the best-known health care systems in the world. Among the WHO Member States, the Saudi health care system ranked 26 according to WHO criteria,

which was based on how far health systems are achieving their goals and how efficiently they are using their resources in doing so (WHO, 2000).

However, it has been noted that the rapid acquisition of national wealth has led to more emphasis on the number of hospitals and PHCCs and the importance of using technology for medical interventions. This has required the country to recruit physicians from abroad as the huge demand for the health care service cannot be met by local physicians (Searle and Gallagher, 1983).

Although the Saudi health care system is comparable to those in the developed world, the system is not without its challenges. The Saudi health system is challenged by a shortage of national health care providers (Searle and Gallagher, 1983, AL-Ahmadi and Martin, 2005, MOH, 2012). Health care services are therefore mainly provided to the population through IMGs.

1.5 IMGs in Saudi Arabia

IMGs are mostly referred to as "expatriate physicians" in the published literature from SA; however, the current study refers to them as "IMGs" as in most international literature. "IMGs" in this study refers to physicians who were born, and graduated from medical schools outside SA, and who do not share the cultural background of the local people.

1.5.1 The general situation of the IMGs in Saudi Arabia

Immigration policies in SA do not permit people, in general, to visit the country for tourism. Pilgrims are allowed to stay in the country for a relatively short period of time.

Thus all non-Saudi nationals are either workers or dependents of workers in SA (Searle and Gallagher, 1983).

These non-Saudi nationals are mostly manual workers involved in construction projects or routine activities such as building maintenance (Searle and Gallagher, 1983). Additionally, a large number of non-Saudi workers share households with local citizens and perform roles such as chauffeurs for female family members, as women are not allowed to drive, or female housekeepers who are responsible for cleaning, cooking and/or taking care of children. Most high and middle class households employ at least one expatriate domestic worker. These workers usually come from South Asia, Indonesia and Philippines, and rarely from the Arab world.

Expatriate workers are also found in professional fields such as petroleum production, engineering and health care. These expatriates enjoy more privileges than less-skilled expatriate workers, such as owning a vehicle and bringing dependents into the country (Searle and Gallagher, 1983).

The first group of non-Saudi workers entered SA more than 45 years ago, as engineers and geologists who worked in petroleum production. At that time they were welcomed by the local citizens as they contributed as "income producers". However, as the years progressed, less skilled expatriate workers were employed to participate in the huge projects that evolved as a result of rapid economic development. The national citizens did not see these expatriate workers as "income producers" any longer (Searle and Gallagher, 1983).

1.5.2 IMGs in the primary health care centres

In relation to the healthcare workforce in SA, the number of IMGs greatly exceeds that of Saudi physicians. IMGs form around 80% and 75% of the total physicians working in the PHCCs and the MOH hospitals around the country, respectively (MOH, 2012). They are particularly concentrated in the Riyadh region, where there are 789 IMG GPs, compared to 297 of their Saudi counterparts, working in 435 PHCCs.

The MOH considers the presence of a majority of international workers in the health profession as a challenge, as they cause instability to the system due to their high turnover rate (WHO, 2006). Nevertheless, the MOH employs IMGs on annually-renewed contracts, which may add to this high turnover rate, and do not treat IMGs with longer experience of working in SA any differently to newly-arrived IMGs in terms of remuneration. Salaries for IMGs who work under the MOH are much lower than those given to their Saudi counterparts, while the duties involved are the same. The MOH does not provide a structured programme to train IMGs, however IMGs are required to complete a number of hours attending conferences and workshops of their choice each year. Additionally, when discussing quality of care in SA, most authors acknowledge the fact that the majority of physicians are IMGs as a challenge to the health care system. They also mention the MOH plan to train national physicians, in SA and abroad, as a way to improve the quality of care and increase the number of national physicians (Khaliq, 2011, Almalki et al., 2011) although it has been shown that Saudi medical graduates tend to specialize in the major disciplines of medicine, such as surgery, leaving the country more reliant on IMGs to provide primary health care (Jarallah et al., 1994, Gallagher and Searle, 1985).

In recent years, the Saudi government has been encouraging Saudi people to enter the medical field by establishing more medical schools around the country, which only accept nationals. However, although the number of Saudi physicians has increased, the proportion of IMGs among the total number of physicians has barely changed because of the increasing demand on health care services (MOH, 2012, MOH, 2009, MOH, 2005, Gallagher and Searle, 1985).

Finally, it worth noting that in SA dietitians and health educators are found in secondary and tertiary care hospitals but not in PHCCs. This makes GPs in the PHCCs, who are mostly IMGs, responsible for all aspects of management, including educating patients about their conditions and supporting self-management including giving lifestyle advice.

1.5.3 IMGs' eligibility to work in SA

Typically, the Saudi MOH advertises their need to recruit physicians in specific countries. They specify a time and a venue where applicants can register and undergo an interview by a recruiting committee that is sent by the MOH. To be able to apply to work in SA, IMGs are required to pass the Saudi licensing exam (SLE), the exam taken by Saudi medical graduates to work in the health care service under the MOH.

The SLE exam is prepared by the Saudi Commission for Health Specialisties (SCHS). IMGs take this exam outside SA in order to apply for a permit to work in SA. The exam is conducted in the English language for all applicants, including Saudis, and it tests medical knowledge of the main medical specialties. IMGs are not required to speak Arabic to be able to pass the exam or work in SA, as English is the operational language

used in all hospitals. Nonetheless, most of the Saudi population does not speak English and state school students are introduced to basic English only after elementary level.

According to the SCHS, IMGs who wish to work as GPs in the PHCCs are required to have a bachelor's degree in medicine while those who work in the hospitals are called "family physicians" and are required to have a bachelor's degree in medicine with residency or a postgraduate degree in family medicine.

Most IMGs working in PHCCs in SA come from Egypt, Sudan and Syria, from the Arab world; and Pakistan, India and Bangladesh from the non-Arab world. Unlike IMGs working in Saudi hospitals, IMGs selected to work in the community-based PHCCs are required to be Muslims.

1.6 Summary

Eating habits and sedentary lifestyle adopted by most Saudi people have contributed to the increasing prevalence of T2DM, which is reaching epidemic proportions in SA. Patients with T2DM are mostly followed by IMGs who constitute around 80% of primary health care physicians.

The employment of large numbers of IMGs is needed in SA to cover health care service demands, yet this situation may have implications in terms of the quality of communication between doctors and patients, as they do not share the same cultural and/or linguistic background, and therefore may have an impact on the quality of the care delivered.

Chapter 2

History, definitions and models of cultural competence

2.0 Introduction

The compelling need for cultural competence has been recognized due to the current and projected change in the demographic makeup in most parts of the world (Kodjo, 2009, Papadopoulos et al., 2004). For example, the Office of National Statistics in the UK announced that migrants to the UK significantly increased from 154,000 to 212,000 in a period of 12 months, from 2012 to 2013. This change led to the existence of cross-cultural encounters in most fields, and the medical field is one example.

In multi-cultural communities it is probable that physicians from the local community have to deal with patients from another community who come from a different culture and may bring different health related beliefs, values and behaviours, than that of the physicians' (Betancourt, 2004). This has led organizations and providers to acknowledge the importance of delivering culturally competent care to immigrant patients to overcome cultural barriers in the clinical encounter.

This chapter analyses the concept of cultural competence, its origin and definitions, as well as providing a historical overview of the various theoretical models.

2.1 Search strategy

In order to identify models of cultural competence, the researcher identified one bibliographic paper on a cultural competence model (Shen, 2004) using Google Scholar and used the 'pearl growing' technique to identify further relevant papers in this field. This technique involved retrieving reference lists and citations from the Shen (2004) paper and other related papers and following them up to grow the body of included literature. Information about the history and definitions of cultural competence were gathered from the identified papers and from a scope search in Google Scholar. Using the search terms 'cultural competence', 'history of cultural competence in healthcare' helped in achieving the aim of this search, which was to gather background information about cultural competence in healthcare. The search continued until no more significant materials could be found.

2.2 The origin of cultural competence

Madeleine Leininger, a nurse based in the US in the 1950s, and the founder of culture care theory, was the first to realize, the need for culture care to be incorporated into the holistic view of patients' state. Leininger was the first to note that nursing care was uni-culturally focused, while the nation was rapidly becoming multicultural, and that health care provision for refugees, immigrants and minority ethnic groups could no longer be ignored. She believed that it is one of the patients' rights to have their values, beliefs and needs met by their caregivers (Leininger, 1995).

She believed that the relationship between health professionals and patients should be built with a focus on achieving health and well-being. However, in order to achieve this,

health care professionals should be aware of and provide culturally sensitive care to the culturally diverse population (Leininger, 1995).

Leininger presented the concept of culturally competent care as a pioneer in the belief that peoples' health and care related beliefs and practices are significantly influenced by their cultures. Its goal is to assist and support people from minority ethnic groups to maintain and improve their health and well-being (Leininger, 1995). She recognised that the concept of "care" has different meanings in different cultures and can only be determined by examining peoples' norms, beliefs, values and life practices that are learned, shared and handed down (Leininger, 1995).

In the mid 1950s, Leininger recognized that interpreting care, delivered by health care professionals, as culturally sensitive or not, is also complicated by the fact that, not only concepts of care, but health and illness states are also strongly influenced by culture.

Additionally, Leninger (1995) advised health care professionals not to judge patients from other cultures as ignorant or lacking modern medical knowledge as they may be simply accustomed to another form of medical knowledge for example, traditional medicine, which can be described as *different* rather than *wrong*. She also explained that the care provided by professionals who adapt their care according to patients' expectations is more effective than that of professionals who expect patients to make all the adjustments.

Further research led Leininger to develop a Cultural Diversity and Universality Theory (CDUT) (Leininger, 1995). This theory focuses on differences, or "diversities" and commonalities, or "universalities" of care practices transculturally. It has practical features that are depicted by the Sunrise model (Figure 2.1) (Leininger, 2002).

CULTURE CARE

Worldview

Cultural & Social Structure Dimensions

Kinship & Social Factors

Cultural Values, Beliefs & Lifeways

Political & Legal Factors

Environmental Context, Language & Ethnohistory

Religious & Philosophical Factors

Economic Factors

Influences

Care Expressions Patterns & Practices

Technological Factors

Educational Factors

Holistic Health / Illness / Death

Focus: Individuals, Families, Groups, Communities or Institutions in Diverse Health Contexts of

Generic (Folk) Care

Nursing Care Practices

Professional Care—Cure Practices

Transcultural Care Decisions & Actions

Culture Care Preservation/Maintenance
Culture Care Accommodation/Negotiation
Culture Care Repatterning/Restructuring

Code Acute viral disease caused by the human

© M. Leininger 2001

Culturally Congruent Care for Health, Well–being or Dying

Figure 2.1 Sunrise model (Leininger, 2002)

The Sunrise model describes the interrelationship of CDUT and presents culturally based factors influencing health, well-being and illness that nurses should think about when dealing with patients from different cultures. She preferred to think about this model as a cognitive map, rather than a theoretical model, that assists health care professionals to build the knowledge necessary to deliver culturally congruent care.

Leininger defined culture as:

> *"The learned, shared, and transmitted knowledge of values, beliefs, norms, and*
>
> *life ways of a particular group that guides an individual or group in their*
>
> *thinking, decisions, and actions in patterned ways" (Leininger, 1995, p.9)*

26

Therefore, the theory made it challenging for health care providers to decide the dimensions in peoples' culture that influence their health and shape their expectations of care. In the Sunrise model, which encompasses the practical features of the theory, these dimensions were identified and they are: technological factors; religious and philosophical factors; kinship and social factors; cultural values, beliefs and lifeways; political and legal factors; economic factors, and educational factors. All these factors, according to Leininger, are not independent but interrelated (Leininger, 1995).

The CDUT assumes that individuals' experiences of indigenous care, or professional care shape the concept of care in different cultures and it is essential for health care providers to have a knowledge base about individuals' expectations, that stems from their experiences, to gather information concerning differences and similarities in regards to health beliefs and practices (Leininger, 1995).

After acquiring information on peoples' worldview and care expectations, health care professionals are expected to use one of the following three modalities with an aim to guide decisions and actions that best fit the situation. The modalities are: 1) Cultural care preservation and/or maintenance; (2) cultural care accommodation and/or negotiation; and, (3) cultural care patterning or restructuring (Leininger, 1995).

Leninger (1995) directed special attention to the role of religion in individuals' health. She explained that religion, like culture, strongly influences peoples' beliefs, interpretations and responses. For example, religion may propose teachings that discourage, or encourage, unhealthy behaviours such as smoking and alcohol abuse. According to her, religion can also be considered as a type of medicine. She suggested for example, that religious people, because of optimism related to their religious belief,

may be less prone to the adverse health impact of psychological or emotional stresses. If practitioners are of a different belief system to their patients, misunderstanding can be expected. Therefore, practitioners should not only be aware of the different religion-related health belief systems, but should also understand these and take them into account in their discussions with their patients.

In general, it is important for healthcare providers to acknowledge differences and similarities between their culture and that of their patients, including all the cultural elements noted earlier, and to be sensitive to sub-cultural differences.

2.3 Definitions of cultural competence

The literature on cultural competence shows a general agreement on its concepts and common elements. In the field of nursing, in the US, according to Camphinha-Bacote's (1999) and Betancourt's et al's (2003) definitions, cultural competence implies delivering effective care by health practitioners who are expected to understand and appreciate variations of health beliefs and behaviours within cultural groups.

The UK NHS trusts have not agreed on one unique definition of cultural competence. The Central and North West London Foundation Trust, in the following definition, focused on the importance of dealing with patients fairly, in terms of human rights, to deliver culturally competent care, as described here:

"Cultural Competency involves an individual's ability to treat every person with dignity, respect and fairness, in a way that is sensitively responsive to differences and similarities, and thereby contributes to creating a genuinely inclusive culture" (NHS, 2014a)

On the other hand, NHS Health Education East of England looked at cultural competence from another perspective. Their definition stated that:

"Cultural competence is the ability to provide care to patients with diverse values, beliefs, and behaviours, and tailoring healthcare delivery to meet patients' social, cultural and linguistic needs. In essence, it is the ability to interact effectively with people of different cultures and address health inequalities" (NHS, 2014)

Although the former definition emphasised the idea of human rights, while the latter focused on cultural competence elements, they both share a common notion and, more or less, similar components. Additionally, the latter definition by the NHS Health Education East of England expanded to specifically introduce the importance of the interaction in the medical cross-cultural encounter.

Furthermore, Papadopoulos (2003), agreed with the general meaning of the previous definitions and highlighted the notion of trans-cultural health, defining it as follows:

"The capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs ... trans-cultural health is the study of cultural diversities and similarities in health and illness as well as their underpinning societal and organisational structures, in order to understand current healthcare practice and to contribute to its future development in a culturally responsive way" (Papadopoulos, 2003, p.5)

Other authors (Stewart, 2002, Ahmed and Bates, 2012) decided to involve "clients" and referred to the term "cultural competence" in healthcare when discussing their perception

of the service as being in harmony with their cultural and religious beliefs and not just provided by culturally sensitive providers. This can be specifically important because the whole idea of providing culturally competent care is to benefit patients by improving the quality of care provided to them and achieving their satisfaction with healthcare provision.

Cross et al's (1989) definition, is widely adopted by a large number of authors, especially in the US (Stork et al., 2001, Brach and Fraserirector, 2000, Anderson et al., 2003) probably because it presents all the elements required to deliver culturally competent care and as it is adopted by the United States Department of Health and Human Services. They defined it as

> *"A set of attitudes, skills, behaviours, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups" (p. iv)*

Culturally competent health care could be compromised when ethnic minorities are cared for by providers from the dominant population, in the same way that they care for the majority; and physician's own individual values complicate the situation (Leininger, 1995, Betancourt, 2004). Thus, the goal of culturally competent care is to provide a system, and train the health workforce to offer high quality care, taking into account the ethnicity, race, religion, culture, and language of every patient.

Cultural competence is an important component in delivering quality care (Henderson et al., 2011, Renzaho et al., 2013). Knowledge of cultural customs allows health care providers to deliver better care and help avoid misunderstandings among staff, patients, and families (Anderson et al., 2003).

Overall, it seems from the definitions of cultural competence that there is a remarkable similarity in its general concepts and common elements. It appears that many obstacles faced what had started as a "one size fits all" model of healthcare approach, and cross-cultural interaction is one of them. The main goal of providing culturally competent care is to be sensitive to patients' different cultural values and to reduce the health gap between ethnic minorities and the general population, and improve the quality of health care and treatment outcomes (Betancourt et al., 2003, Henderson et al., 2011, Renzaho et al., 2013).

It should be noted however, that all the definitions of cultural competence discussed focus on providers dealing with various patients' health beliefs to achieve equality and reduce the health gap among ethnic minority populations, while none of them are based on health providers from ethnic minority populations caring for patients from the ethnic majority. Despite this, both situations share the same elements required to achieve a successful cross-cultural interaction, even if they do not share exactly the same goals, as the latter situation aims to achieve more general goals concerning providing high quality culturally sensitive care to patients who belong to the host culture.

2.4 Historical overview and critique of cultural competence theoretical models

Most publications in cultural competence development and its applications started in the early 1990s, although the concept was recognised four decades before that (Shen, 2004).

Before 1990 there were few publications in this field. As a result of the emergence of more culturally diverse societies which needed culturally appropriate care, the need for more research was acknowledged by healthcare providers, mainly those in the US (Leininger, 1995). Throughout the following years, researchers concentrated on refinement, modifications and updates to the model published first by Leninger (Campinha-Bacote, 2002, Purnell, 2000, Orque, 1983).

It is noticeable from the literature that nursing research in cultural competence, theory and practice, has made a unique contribution to the health care, as most studies in cultural competence and its frameworks were developed in the nursing field (Purnell, 2002, Leininger, 1995). The concept of cultural competence developed in the nursing field has subsequently been more widely applied to disciplines other than nursing where cross-cultural communication and interaction, as well as culturally congruent health care based on mutual understanding, are needed, such as with primary health care physicians (Dunn, 2002, Paez et al., 2008).

The recognition of the high demand for culturally competent care has encouraged researchers to develop theoretical models and practical frameworks to encourage health care providers to become culturally competent.

Orque (1983) developed Leininger's Sunrise model in terms of a more individualised focus by developing the ethnic/cultural framework. Her framework explained that there are basic human needs that are influenced by major domains in culture and affect people's behaviours and practices such as diet, religion, family life processes, health beliefs and practices, language and communication processes, social group interactive patterns, value orientation, arts and history. All these cultural components are

interrelated and human needs are able to adapt to environmental changes, which include changes within these components. According to Orque, the relationship between these components and human needs forms what he referred to as an "ethnic/cultural system" (Orque, 1983).

Orque encouraged healthcare professionals to consider biological, psychological and physiological systems as they greatly influence the ethnic/cultural system. These three systems significantly influence individuals' beliefs and practices and may cause alterations in the cultural domains that were mentioned earlier (Orque, 1983).

Cross et al. (1989) were the first to use the term *cultural competence* in their study of improving service delivery to emotionally disturbed minority children. They argued that the developmental process of becoming culturally competent is based on a continuum, which is reflected by a transformation process from an ethnocentric system to appreciating cultural differences and being culturally professional.

In 1998, Campinha-Bacote, another dominant researcher in the field of cultural competence (Campinha-Bacote, 2002), took Leininger's model and Crosse's concept to a more practical level by presenting the cultural competence process in healthcare delivery as a model to guide nursing practice. The author focused on presenting cultural competence as a process rather than a state of being, as the components that shape a culture and a sub-cultural individual, require health care providers to continuously adapt to the different patients to whom they deliver care. The model consists of five main stages, which are:-

Cultural awareness: the process of in-depth exploration of one's own cultural background. It involves recognizing prejudice and assumptions about different people.

When professionals are aware of the influence of their own cultural and professional values, they are less likely to impose their own values on people of a different culture (Leininger, 1995).

Cultural knowledge: the process of learning patients' culture and specifications, including learning health and illness related perceptions, epidemiological data of a particular group and ethnic pharmacology.

Cultural skill: the ability to gather culturally relevant data concerning patients' health presentation and to perform culturally based physical assessment. Culturally competent physical assessment means considering patients' biological, physical and physiological characteristics when evaluating these patients. Examples include appreciating peoples' skin colour and laboratory variations during medical assessment.

Cultural encounter: the engagement of the health care provider with patients of a different culture to develop a better insight about intra-ethnic variations. This may help in minimizing stereotypical actions, as the health care provider can be more experienced in different health practices within a certain group.

Cultural desire: the motivation of health care providers to want to, rather than have to, be aware, knowledgeable, skilful and familiar with the cultural encounter of other cultures. It includes feeling passionate about caring for patients, rather than being biomedically "correct", learning from them, being aware of the differences and building on the commonalities that they share. This was referred to by Tervalon & Murray-Garcia, 1998, as *cultural humility*.

Wells (2000) offered the Cultural Development Model (CDM) that focuses on the gradation in the process of becoming culturally competent. Nonetheless, the process is

more or less similar to that described by Compinha-Bacote (2002). CDM consists of six developmental stages that fit into two different phases and are based in a continuum. According to this model, a transformation to culturally competent care can only occur when professionals and organisations progress through the following phases (Wells, 2000): The first phase is the cognitive phase, which includes cultural incompetence, cultural knowledge, and cultural awareness. These stages gradually allow providers to move from the state of unfamiliarity to one of familiarity with the influence of culture on individuals' health practices. The second phase is the affective phase, which includes cultural sensitivity, cultural competence, and cultural proficiency.

Later, Purnell (2000) developed the Purnell Model for Cultural Competence (PMCC) based on his claim that conscious commitment from health care providers is required in the process of cultural competence. Similar to Well's model (2000), the PMCC emphasises the progression of the process of cultural competence, but this is described differently: 1) unconscious incompetence, which is the lack of awareness; 2) conscious incompetence, which is knowledge of the lack of awareness; 3) conscious competence, which is the familiarization with cultural norms and providing culturally congruent care; 4) unconscious competence, which is the automatic provision of cultural competence. Purnell warned against unconscious competence, as it can be dangerous if sub-cultural differences are overlooked.

Kim-Godwin et al. (2001) argued that most attempts to develop frameworks and models in cultural competence have been directed toward health care providers while no attempt has been made to explain the effect of cultural competence care in community settings. Community and public health care providers were facing challenges in terms of providing

35

culturally competent care, especially after the rapid shift to community-based care compared to hospital-based care (Kim‑Godwin et al., 2001). The authors presented the Culturally Competent Community Care model (CCCC). This model consists of three main constructs, namely cultural competence, health care system and health outcomes, and it mainly focuses on the effect of culturally competent care on public health outcomes among culturally diverse populations.

Pacquiao (2008) looked at providing culturally competent care from another angle. In line with the Central and North West London Foundation Trust's definition of cultural competence, Pacquiao saw this as a basic human right, stating that it is necessary to consider ethical care in providing culturally competent care. To guide health professionals to provide culturally congruent care for people of various cultures when they face ethical decisions, the author developed the culturally competent model of ethical decision-making.

The model calls for healthcare professionals to familiarise themselves with the patients' world view, including life and death, concept of soul, family structures, experiences and modern medicine. After assessing patients, the model calls for assessing organisations and professionals and then planning for and identifying the expected outcomes based on the patients' worldview. Considering patients' viewpoints during this phase facilitates respect and a trust-based relationship between providers and their patients. For his intervention phase, he borrowed Leinnger's modalities of actions. The evaluation phase, according to the author, should not only include biomedical results but should also consider measuring outcomes based on the patient's interpretation of health and illness (Pacquiao, 2008). Once again, the care receivers' interpretations of care provision and its

consequences are acknowledged, which indicates the importance of patient satisfaction as a factor that influences the quality of care.

2.5 Cultural competence and patient-centred care

The literature review identified some opponents to the concept of cultural competence. For example, Dreher and MacNaughton (2002) argued that cultural competence is a fallacy. They declared that although individuals are considered "carriers" of their cultural traditions, the notion of cultural competence assumes that all patients from the same culture have the same belief system, whilst in reality, people differ in their level of adherence to cultural traditions. Unlike in the public health area where decisions and interventions are applied to communities in which the behaviours of the majority should be considered, health care services in clinics are dispensed to individuals, thus it is of great importance to appreciate the differences between people of the same cultural background (Dreher and MacNaughton, 2002). The authors, therefore, assume that cultural competence at the patient-provider level is merely another name for patient-centred care.

Cultural competence, in its essence, is about communication. Patient-centred care is a model of communication in this context (Stewart, 2001). Stewart *et al*. (2001) noted that:

> *"Patients want patient-centred care which (a) explores patients' main reasons*
> *for the visit, concerns, and need for information; (b) seeks an integrated*
> *understanding of patients' worlds – that is, their whole person, emotional*
> *needs, and life issues; (c) finds common ground on what the patient's problem*
> *is and mutually agrees on management; (d) enhances prevention and health*

promotion; and (e) enhances the continuing relationship between the patient

and the doctor" (p. 445)

Evidence suggests that patient-centredness has a positive impact on the quality of care (Kinmonth et al., 1998, Stewart, 1995). However, it should be noted that, like cultural competence, different interconnected components play major roles in structuring the interaction process between patients and physicians, as shown in figure 2.2 (Aita et al., 2005).
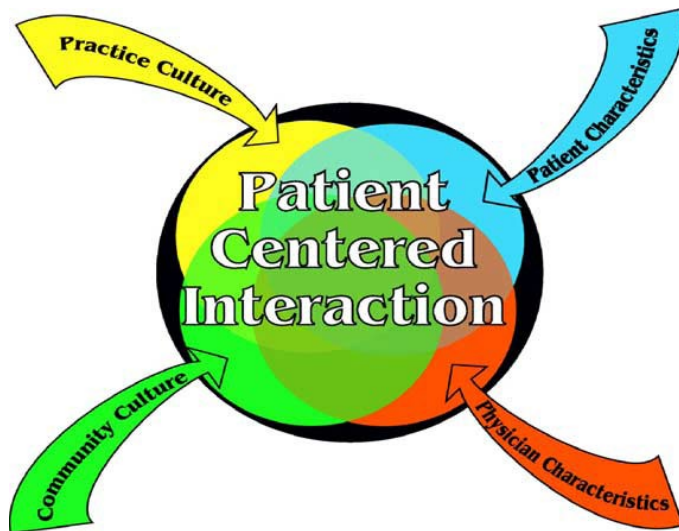
Figure 2.2 Patient-centred interaction model (Aita et al., 2005).

The concepts of patient-centeredness and cultural competence are overlapped (Beach et al., 2006). Figure 2.3 shows features in which both concepts overlap at the interpersonal level.

Patient-Centred

Cultural Competence

• Curbs obstructive behaviour such as using technical language, frequent interruptions, or false reassurance
• Understands transference and counter transference
• Understands the stages and functions of a medical interview
• Attends to health promotion and disease prevention

• Understands and is interested in the patient as a unique person
• Uses a biopsychosocial model
• Explores and respects patient beliefs, values, meaning of illness, preferences, and needs
• Builds rapport and trust
• Finds common ground
• Is aware of own biases and assumptions
• Maintains and is able to convey unconditional positive regard

• Understands the meaning of culture
• Is knowledgeable about different cultures
• Works with local community
• Appreciates diversity
• Is aware of health disparities and discrimination affecting minority groups

Figure 2.3 Overlap between patient-centred care and cultural competence at the

interpersonal level (Beach et al., 2006)

Both concepts are better applied under a culturally competent system, which can be characterized by: workforce diversity reflecting patient population; availability of language assistance; ongoing staff training to deliver culturally and linguistically competent service, and satisfaction of performance data by race/ethnicity (Beach et al., 2006).

Saha et al. (2008) argued that although cultural competence and patient-centred care overlap in many elements and have the same overall aim of improving health care quality, they differ in terms of the aspects of quality which they emphasize. The primary aim of cultural competence is to reduce inequalities in healthcare while the aim of

patient-centred care is to provide individualized care (Saha et al., 2008). Additionally, some of the developers of the cultural competence models, for example Orque (1983) and Purnell (2000), warned against practicing unconscious cultural competence, which may overlook individual differences.

2.6 Summary

In summary, culturally competent care can only be developed through training, experience, guidance and self-evaluation. Additionally, the concept of cultural competence in health care has to be applied not only on a professional level, but also on an administrative level. The need for culturally competent care was recognised more than five decades ago. Since then, more attention has been given to the application of the concept of cultural competence through the development of its models, and clearer ideas concerning practicality were added to the notion of cultural competence. Cultural competence is a complex concept required to successfully meet the needs of patients of different cultural backgrounds from that of health care providers. Cultural competence can be learned and requires continuous reflection by health care providers. It can be understood that cultural competence is not a communication technique that one can master, rather, it is a way of thinking about, understanding and interacting with people (Dunn, 2002). Furthermore, the main focus of cultural competence models and frameworks is to avoid ethnocentric assessment in order to provide care that is responsive to the recipients' perspectives. Last but not least, cultural competence and patient-centred care are two complex concepts that overlap in many components, yet differ in terms of the aspect of quality which they emphasize.

The concept and models of cultural competence were recognised and developed based on the common picture of local health care providers caring for a culturally diverse population however, it seems logical to assume that the notion of cultural competence in health care could be applied to international health care providers caring for local patients.

Chapter 3

Literature review

3.0 Introduction

Having discussed the concept and models of cultural competence, it is important to understand if and how cultural competence is related to quality of care. This chapter begins by reviewing literature on the effectiveness of cultural competence training in terms of the provision of quality healthcare. The second section, 'cultural similarities and workforce diversity', presents the literature exploring the experiences of IMGs and the factors which influence their relationship with local patients to whom they provide health care. The final section reviews the Saudi-based literature with regards to cross-cultural care.

3.1 Search strategy for the literature reviews

Three separate searches were carried out for the three differing bodies of literature in this chapter and each is described below.

3.1.1 Cultural competence training and quality of care

To identify papers exploring the relationship between cultural competence and quality health care, an online search was conducted using MEDLINE/OVID, CINAHL and Web of Knowledge databases, published in English between 1946 and 2014, in addition to Google Scholar. The search terms included: cultural competence/training, intervention, education/ effectiveness, outcomes, satisfaction, communication and quality care. This search yielded 175 papers (see Appendix 1 for prisma chart). Studies conducted on the effectiveness of cultural competence interventions among health professionals, as well as students, were included, as the goal was to assess changes in culture-related knowledge and attitude, and the effect of these changes on patients. Studies focusing on patient-centred care with cultural competence components were also included. Papers were excluded if they discussed culturally competent health care systems or cultural competence in other fields, such as dentistry. Seven systematic reviews (Allen, 2010, Beach et al., 2005, Chipps et al., 2008, Henderson et al., 2011, Lie et al., 2011, Renzaho et al., 2013, Horvat et al., 2014) and one primary study (Carter et al., 2006) met the inclusion criteria. The reviews included studies from the US, Canada, UK, Australia, Finland and Switzerland (see section 3.2 below).

References and citations found in the reviews selected were also searched for relevant papers.

3.1.2 Cultural similarities and workforce diversity

To find studies published on IMGs' experiences of communicating with local patients, an online search was conducted. MEDLINE/OVID, CINAHL and Web of Knowledge databases were searched, for articles published in English from 1946 to the present, along with Google Scholar for related papers. The search included the following key words: Immigrant, foreign, international, expatriate and overseas trained physicians/ experiences, challenges/ cultural competence. This search produced 798 papers of which 13 were included (see Appendix 2 for prisma chart), 10 qualitative and 3 quantitative (Searight and Gafford, 2006, Dahm, 2011, McDonnell and Usherwood, 2008, Jain and Krieger, 2011, Fiscella et al., 1997, Hall et al., 2004, Dorgan et al., 2009, Diaz and Hjorleifsson, 2011, Louis et al., 2010, Zeighami et al., 1978, Harding et al., 2010, McGrath et al., 2012, Slowther et al., 2012). Studies were included if they examined the experiences and challenges faced by IMGs and/or local patients at the interpersonal level, or if it appeared from the study's abstract that challenges and/or facilitators to cross-cultural communication between IMGs and local patients were identified in a study as a secondary theme or outcome. Papers were excluded if they addressed cross-cultural communication in relation to academia and working environments. No systematic reviews were found. Reference lists and citations included in the related studies were screened for relevant papers.

The studies included came from the UK, Canada, US, Australia, Norway and Iran. For a better comprehension of IMGs' experiences and the challenges they encountered, thematic synthesis was used to present the studies that were featured (Thomas and Harden, 2008). Themes emerging from the synthesis were cultural issues in the IMG-

patient medical encounter, rapport and emotional support, patient-physician power dynamic, patients satisfaction and trust, prejudice towards IMGs and language barrier in the IMG-patient medical encounter (see section 3.3 below).

3.1.3 Cultural competence in SA

An online search using MIDLINE/OVID and Google Scholar was conducted to look for Saudi-based research with a focus on investigating cultural competence among IMGs from 1946 to the present. The search terms used included: Physician, doctors/expatriates, IMGs, overseas trained, immigrants, foreign, international/Saudi. The search yielded only 8 articles, none of which included IMGs. However, because the concept of care is shared between GPs and nurses, and almost all the studies focused on international nurses, it was decided to include Saudi-based studies that looked at international nurses caring for local patients.

Due to the limited amount of research regarding international health workers in SA, and the need to fully understand both the challenges and the facilitators experienced by them, all papers concerning international health workers were included, including review papers.

Four papers were included in the review. One was a qualitative study (Halligan, 2006) and three were review papers (Aldossary et al., 2008, Mutair et al., 2014, Luna, 1998). All the featured papers looked at international nurses in SA (see section 3.4 below).

3.2 The effectiveness of cultural competence training in terms of quality of care

As needs for culturally competent health care increase, attention has been focused on examining the effectiveness of physicians' cultural competence in terms the quality of

care delivered to patients. The first body of literature reviewed examined the effectiveness of cultural competence on the quality of care through intervention applications. Thus, the following section presents evidence on the effectiveness of these cultural competence interventions.

3.2.1 Cultural competence and quality of healthcare

The Institute of Medicine in the US has defined quality in health care as

"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lohr, 1990, p.21)

The UK NHS identifies the quality of its care by looking at patients' safety, the effectiveness of the treatment received, and patients' feedback about the care received (NHS, 2013 a). According to the Care Quality Commission (CQC) in the UK, these elements can be delivered by effective collaboration between patients and physicians, clear communication and explanation, and providing what they described as "compassionate" care that considers human rights when dealing with patients (NHS, 2013 b, NHS, 2013).

According to Donabedian (1988), quality can be looked at from three positions: *structural quality* which includes health system characteristics, *process quality* which is concerned with patient-physician communication, and *outcome quality* which proposes evidence on changes of patients' health status. Although outcome is considered a measurement of quality, it has been argued that patients perceive quality in terms of providers' approach in areas such as communication and rapport building style, rather than physicians' technical styles in relieving symptoms (Chilgren, 2008).

As mentioned in 2.5, healthcare can be described as "culturally competent" if both professionals and organisations work together to equip themselves with the appropriate skills and systems. In addition, quality healthcare should be achieved at all structural, process and outcome levels. This section of the literature review focuses on the quality of care at the patient-physician interpersonal level and its relationship to quality care.

3.2.2 The effectiveness of cultural competence interventions

The plethora of literature that examined the effectiveness of cultural competence training led to several recent efforts to systematically review this issue (Allen, 2010, Beach et al., 2005, Chipps et al., 2008, Henderson et al., 2011, Lie et al., 2011, Renzaho et al., 2013). This search yielded seven systematic reviews, all of which were included to ensure coverage of all findings. Among the systematic reviews, there was an overlap of ten studies, which were included in at least two different reviews (Wade and Bernstein, 1991, Way et al., 2002, Mazor et al., 2002, Majumdar et al., 2004, Thom et al., 2006, Crandall et al., 2003, Gallagher-Thompson et al., 2000, Smith, 2000, Tang et al., 2002, Williamson et al., 1996).

The reviews differ in their scope and the population on whom they focused in order to find the effect of cultural competence interventions. Chipps et al (2008), for example, were interested in reviewing studies on the effectiveness of cultural competence training for health professionals, specifically in community-based rehabilitation centres. Additionally, some of the reviews looked at providers in general, including physicians and nurses (Chipps et al., 2008, Beach et al., 2005), others focused on nursing students (Allen, 2010) or health care professionals and/or students (Renzaho et al., 2013, Lie et al., 2011) while some were additionally interested in studies that included patients' input

concerning this issue (Lie et al., 2011). Furthermore, some of the reviews focused on patient-centred care training, which included cultural competence components (Renzaho et al., 2013) or the effect of the latter on patient-centred outcomes (Lie et al., 2011).

Beach et al., who reviewed 34 studies that evaluated cultural competence interventions on students, physicians, nurses and health workers, published their first review in 2005. The review found strong evidence that suggested that cultural competence training improves health professionals' knowledge of patients from different cultures, as well as making their attitude towards these patients more positive, thus enhancing their skills in dealing with them. They also found that cultural competence training impacts patients' satisfaction. A subsequent study undertaken by Carter et al. (2006) assessed the effectiveness of cultural competence workshops on 196 third year medical students' attitudes in the US, using a cultural attitudes and belief scale which contained 11 items. Carter et al's (2006) found significant positive attitudinal changes in relation to most of the items post-workshops compared to pre-workshops.

Similar findings were found in the Chipps et al. (2008) review, which included the former review (Beach et al., 2005), in addition to five more studies, and focused mainly on evaluating cultural competence training in community-based rehabilitation centres.

Lie et al. (2011) and Renzaho et al. (2013) examined the effectiveness of cultural competence training on patient-centred outcomes and on patient-centred care, respectively, incorporating cultural competence components. The reviews suggested that training healthcare workers in patient-centred, culturally competent care increases their awareness, knowledge levels in terms of dealing with culturally diverse populations, cultural sensitivity and patient satisfaction.

Allen (2010) in his review examined the effect of cross-cultural care and anti-racism education on nursing students. He included 13 studies in his review, and found that while cultural competence training showed positive attitudinal and belief changes, racism persisted despite anti-racism education. It should be mentioned however, that the review only found one study that included anti-racism education (Hagey and MacKay, 2000).

A systematic review by Henderson et al. (2011) looked at the effectiveness of culturally appropriate interventions to manage or prevent chronic diseases in ethnically diverse populations. The review included 24 studies focusing on the use of interpreters, bilingual providers and cultural competence training. Only four studies looked at cultural competence training for healthcare providers. These studies were conducted in three different countries, the US, Canada and Switzerland, and their findings suggested that better patient-provider communication and understanding, providers' ability to offer more information regarding future care, and patients' satisfaction with care, could be achieved with providers trained in cultural competency (Henderson et al., 2011).

The Cochrane Library published the most recent review on cultural competence education for health professionals, in 2014 (Horvat et al., 2014). In their review they included randomized controlled trials (RCTs) measuring primarily patient-related outcomes and health professionals-related outcomes as secondary outcomes. They included only five studies, as the majority of the papers in the literature were not RCTs, and patients' outcomes were not part of their study design. The review referred to two of the reviews mentioned earlier (Beach et al., 2005, Lie et al., 2011), which included a broader range of studies. Beach et al, (2005) had one study in common with this review

while Lie et al, (2011), which included seven studies, had four in common with this review.

All the reviews that were included provided a description of the duration and type of interventions, such as educational sessions, workshops and audio and/or visual aids. The training curricula of all the studies featured in the reviews, unless not specified, are based on previously developed models. Price et al. (2005) stated that there are no standard guidelines to help educators to effectively design cultural competence interventions.

However in general, although most of the evidence in this field was described to be of low to moderate quality (Lie et al., 2011, Chipps et al., 2008, Price et al., 2005, Horvat et al., 2014), they all showed positive changes on the providers' side and satisfaction from patients' perspective following cultural competence interventions. The reviews did not specify the most effective type of intervention.

It can be concluded that health professionals' cultural competence can positively influence quality of care through improving physicians' attitudes and skills relating to caring for patients from different cultural backgrounds, thereby improving patients' satisfaction.

3.3 Cultural similarity and workforce diversity

The second body of literature reviewed examined cultural similarity and workforce diversity. The literature was synthesized into themes, and themes emerging were cultural issues in the IMG-patient medical encounter, rapport and emotional support, patient-physician power dynamic, patients satisfaction and trust, prejudice towards IMGs and language barrier in the IMG-patient medical encounter.

Before discussing the emerging themes in detail, it worth noting that the literature on cultural competence and medical cross-cultural communication mainly focuses on experiences in medical encounters between local physicians from ethnic majority populations, with immigrant patients from ethnic minority populations (Mehler et al., 2004, Fernandez et al., 2004, Ryan et al., 2008, Piette et al., 2006, Peek et al., 2011). Although some countries find themselves obligated to rely on IMGs to meet their health development goals and provide for the needs of their population, little attention has been given to the interaction between IMGs and local patients and to the quality of care these physicians offer. In such countries, local patients may be seen by IMGs who do not share the same language and/or culture with the patients they care for.

A study conducted in Norway on the patterns of clinical practice among local and IMG physicians from other parts of Europe, Africa, Latin America and Asia (Sandvik et al., 2012), showed that IMGs do not differ from local medical graduates in terms of medical knowledge. However, they may have different practicing styles: for example, IMGs were more likely to write sickness certificates, use diagnosis related to pregnancy and family planning, and use less psychiatric diagnosis. These differences can be challenging when endeavoring to deliver appropriate care to local patients (Sandvik et al., 2012). Another study found that IMGs are significantly less likely to arrive at the correct diagnosis and provide the right treatment (Kales et al., 2006). Kale et al. (2006) attributed this difference to the fact that IMGs may apply their cultural paradigm regarding certain health conditions to the local country.

In general, IMGs' ability to interact with patients, find the right diagnosis and provide the correct treatment are greatly influenced by their different backgrounds and previous

expertise, all of which they may subconsciously bring to their interviews with local patients (Dorgan et al., 2009, Fiscella et al., 1997, Hall et al., 2004).

The following section examines the studies published on cultural competence among IMGs who care for local patients.

3.3.1 Cultural competence among an ethnic minority workforce

3.3.1.1 Cultural issues in the IMG-patient medical encounter

It is intuitive to presume that better communication can be achieved when physicians and patients come from the same culture and share the same language and local customs. Using in-depth interviews to explore IMGs' experiences and perceived barriers to communication with local patients in the US, Dorgan et al. (2009) found that IMG participants believe that they communicate better with patients in their home countries because they are more familiar with the dynamic of the relationship and the mutual expectations between themselves and their patients. Unmet expectations can lead to patients' frustration, which negatively affect perceived quality of health care (Fiscella et al., 1997). Looking at IMGs' experiences and perceived barriers to communication with patients, and using a combination of critical incident and focus group discussion, Fiscella et al. (1997) found that language and cultural distance between IMGs and their patients might reflect on their care and that these physicians may be perceived by their patients as not participating fully in this (Fiscella et al., 1997).

IMGs in Dorgan et al. (2009), who came from the Caribbean, Colombia, Denmark, India, Iran, Pakistan, and Peru, perceived behaviours of local patients from the Appalachian culture as "strange", "different" and "not very comfortable". Such descriptions by these

physicians might depict the struggle they face when they try to build a relationship with their patients in order to ease medical communication and interaction.

Cultural differences appeared to be acknowledged by IMGs as a contributor to communication difficulties with their patients. Nevertheless, their acknowledgment did not help them to overcome cultural barriers (McDonnell and Usherwood, 2008; Dorgan *et al*., 2009). IMGs, in some of the studies, struggled to adopt a patient-centred approach and provide shared decision-making, as they lacked the local cultural knowledge that would allow them to provide this kind of care (McDonnell and Usherwood, 2008; Dorgan *et al*., 2009; Dahm, 2011; McGrath *et al*., 2012). One IMG featured in McDonnell and Usherwood's study (2008), which explored challenges at the level of physician-patient communication and examined the challenges faced by IMGs working within the Australian health care system, expressed her struggle not to impose her own cultural values. She believed that IMGs bring their heritage and beliefs subconsciously into their practice, which inevitably influence the care provided by IMGs.

By using observation and in-depth interviews, Dahm (2011) explored the patient-centred care challenges and principles adopted by IMGs in Australia. The author found that some of the perceived factors of the difficulties in dealing with patients are environmental and arise from physicians' inability to integrate with the local people as they are considered outsiders. The culturally-related challenges faced by IMGs in communicating with local patients may be most obvious during the informal type of conversation that is often needed at the beginning of a consultation and during one, in order to ease patients' anxiety and stress, and enhance rapport during the interaction. Jain and Krieger (2011) studied the communication strategies used by IMGs in cross-cultural medical encounters

and noted that their IMGs reported a key difficulty in engaging in small talk with their patients. For example, physicians tried to familiarize themselves with football teams to start a conversation, however when asked about a particular player, the superficial knowledge of physicians about this topic became noticeable to the patient (Jain and Krieger, 2011).

While some IMGs try to provide evidence of their integration with the local culture as a strategy to ease communication and facilitate conversation with patients, others use their cultural differences to start a conversation (Jain and Krieger, 2011). For example, IMGs may maintain their accents to initiate communication, although this might create an initial distance as it shows that the physician does not belong to the same background as the patient (Jain and Krieger, 2011).

Despite all the cultural-related communication challenges highlighted by the IMGs, it seems that they believe that they will eventually learn the communication skills suitable for local patients by practice and more exposure to local patients (Dorgan et al., 2009). While some of the 30 IMGs from India, Sri Lanka, South Africa, Sudan, Pakistan, Caribbean, Russia, Philippines, Egypt, Indonesia, Serbia and Afghanistan, in a study examining IMG-patient communication issues in Australia (McGrath et al., 2012), needed a few months to learn the medical culture of the local people, others believed that learning cultural related issues is a slow process and may take years to master. Expressing similar views to those of the former group of IMGs in the aforementioned study, some IMGs in Searight and Gafford (2006) reported rapidly becoming sensitive to local patients' expectations to deliver what has been described as "consumer service".

3.3.1.2 Rapport and emotional support

Patients' expectations of their physicians regarding rapport and emotional support vary in different cultures. For example, IMGs from collectivist cultures such as South Asian and the Middle East, are not faced by the pressure associated with delivering bad news to patients as they leave this responsibility to the family of the patient (Jain and Krieger, 2011, McGrath et al., 2012). IMGs perceive delivering bad news or reassuring patients as a barrier to satisfactory communication with the local Appalachian patients in Doragan et al. (2009). Acting in accordance with their previous practice in their home countries, the IMGs believed that addressing patient emotions does not come as a high priority within the framework of communication. These IMGs believed that taking a proper history and coming up with an appropriate diagnosis and treatment decisions, rather than communicating directly with the patients, are the keys to becoming a good physician, although they do try to adapt to the local system and use strategies to show rapport. For example, Dorgan et al. (2009) found that IMGs would summarize their conversation to show patients that they were listening, something they do not do with patients from their own culture.

IMGs working in more individualist cultures such as the UK and the US recognize that their patients require a different approach from that which they are used to adopting with patients in their home countries (Dorgan et al., 2009, Slowther et al., 2012). For example, an IMG from a focus group in Slowther et al. (2012), which explored non-UK qualified doctors' experiences working within the UK regulatory framework, felt that the focus on patients' autonomy in the UK is a source of anxiety because IMGs have to be aware of the UK's standards of good medical practice, and have to strive to achieve these standards while maintaining this autonomy. Furthermore, seeing patients suffering and

not being able to communicate was perceived by IMGs, in Fiscella et al's (1997) focus group discussion, as a frustrating and challenging situation as they are not sure how to communicate properly in these situations. This indicates that the IMGs have the desire to help and provide optimum care for local patients.

Generally, it can be noted that rapport-building and emotional support styles differ in different cultures. Therefore, IMGs may struggle to find their own ways to properly support local patients.

3.3.1.3 Patient- physician power dynamic

Patients in some collectivist cultures such as South Asia tend to play a submissive role in the clinical encounter. Their physicians treat them according to what they think is better for patients (Dorgan et al., 2009, McGrath et al., 2012, Slowther et al., 2012). This type of relationship has been described as a "vertical", "parental" or "passive" relationship, all of which terms reflect physicians' superiority over patients.

Physician-patient power differentials can be a source of problematic communication (Dorgan et al., 2009, Dahm, 2011, Jain and Krieger, 2011, McGrath et al., 2012). In their home countries, some IMGs are used to a parental communication style in which patients take what physicians say as final (Dorgan et al., 2009, Searight and Gafford, 2006, McGrath et al., 2012). Thus, it might be difficult for them to accept and adapt to a new approach to communicating and interacting with local patients.

Dahm (2011) found that most of the IMG participants, who came from South Asia, the Middle East and Southern and Eastern Europe, faced challenges regarding providing local Australian patients with patient-centred care, which were exacerbated by their

preoccupation with the paternalistic role they used to play in their home countries. Similar findings were evident in Jain and Krieger (2011) and McGrath et al. (2012).

The majority of the IMGs, who came from Jordan, Lebanon, Nigeria, and Philippines in Jain and Krieger's (2011) study, which was conducted in the US, revealed that their adoption of patient-centred care was not by choice, but had been forced upon them due to the Western patients' culture and the medical system's requirements. These IMGs did not show their frustration at the egalitarian physician-patient relationship explicitly; however, this was evident in the expressions they used in their description of the differences between US patients and patients in their home countries, differences they regarded with "surprise" and "confusion" (Jain and Krieger, 2011; Dorgan *et al*., 2009). Furthermore, participants in Searight and Gafford's (2006) qualitative study, which looked at IMGs' previous training and experience in behavioural science before coming to the US, described patients in their home countries as trusting, cooperative and compliant in their interaction with physicians, compared to local patients, as they both share the same values and norms. IMGs in this study came from different parts of the world, including India, Macedonia, Bosnia-Herzegovina, the Philippines, Egypt, and Iraq. In short, IMGs struggle to achieve an egalitarian relationship with patients (Dahm, 2011, Dorgan et al., 2009, McGrath et al., 2012) and meet their expectations, such as providing patient-centred care, as they do not share the same medical culture with their patients. Furthermore, IMGs' different views on physician-patient power dynamics from those of their patients, might complicate clinical interactions with them (Dorgan et al., 2009, Dahm, 2011, Jain and Krieger, 2011, McGrath et al., 2012).

3.3.1.4 Patient satisfaction and trust

A survey by Harding et al. (2010) examined 1127 patient perceptions of IMGs compared to local Australian graduate physicians. Participants revealed high levels of acceptance of and satisfaction with the care provided by IMGs. Nevertheless, one key limitation of this study was that participants' reactions were assessed regarding physicians whom they had personally chosen to be followed-up by in a rural area where most physicians are IMGs. This assumes that patients may have already changed their IMG if they were not satisfied with him or her (Harding et al., 2010).

On the other hand, in a cross-sectional survey Louis *et al*. (2010) looked at 39 patients' perceptions of fictitious contenders for a position as a practitioner in a community practice in Australia. In this study, prospective patients, who were Australian students of European heritage at Queensland University, discounted foreign-born Pakistani candidates trained in Australia or in their home country, perceiving them as less competent and trustworthy, and, significantly, preferred local-born physicians and physicians, including foreign-born, who had been trained in the "First World", defined as high-income, industrialised countries including the US, Canada, and Western Europe in the study.

Zeighami et al. (1978) in a cross-sectional study of 92 foreign physicians from India, Pakistan and the Philippines and of 4555 patients, explored physicians' reasons for accepting to work in a rural area of Iran, and the attitudes of Iranian patients in this area towards foreign physicians. They noted that language was the main reason for Iranian patients to prefer treatment by Iranian health workers. However, other reasons included having had previous unsatisfactory experiences with IMGs, or resentment of these physicians because they came from overseas.

In fact, the literature shows contradictory findings regarding patients' overall satisfaction and trust in relation to IMGs compared to local providers. However, it mostly supports the view that patients tend to trust physicians who share their cultural background more than they trust those they perceive as coming from different cultures.

3.3.1.5 Prejudice towards IMGs

Prejudice and discrimination refer to differential assumptions about or actions toward others according to their race, religion, gender, sexuality etc. (Jones, 2000). Most literature which raised the issue of prejudice towards IMGs focused on the selection, recruitment and evaluation processes in different medical residency programmes (Desbiens and Vidaillet, 2010, Balon et al., 1997). However, little research attention has been given to the same issue in the patient-provider communication process in cross-cultural medical encounters where physicians are IMGs.

Some of Fiscella et al's (1997) IMG participants, in their study assessing trans-cultural challenges in the US among IMGs using focus group discussion and written narratives, reported rejection by patients due to their nationality, which included Pakistani, Indian, Taiwan and Costa Rican, or language. Moreover, Díaz and Hjörleifsson (2011) in their qualitative study, exploring how immigrant GPs in Norway reflected on the influence of their own cultural background on their practice, found that all participants reported experiencing prejudice from Norwegian patients and difficulties recruiting patients to their list because of their foreign names. Equally, IMGs' supervisors have seen racism and low acceptance by patients as challenges to providing optimal communication and hence quality care by IMGs (McDonnell and Usherwood, 2008).

Prejudice towards IMGs might affect their desire to care for their patients (Fiscella et al., 1997). In written narratives, a participant in Fiscella et al's study (1997) described how his anger and frustration following a patient's rejection had made him unable to provide care and had led to an unnecessary argument with the patient.

Overall, it is evident that prejudice and discrimination can exist in the IMG-patient relationship. However, there is a paucity of evidence on the exact causes of the existence of this attitude in the IMG-patient relationship, as well as on the forms it takes and its consequences for this relationship.

3.3.1.6 Language barrier in the IMG-patient medical encounter

Physician-patient language discordance may add further problems to physician-patient communication and interaction in cross-cultural clinical settings. The significance of mutual understanding of spoken language in the clinical settings has been widely acknowledged by IMGs (Jain and Krieger, 2011, Fiscella et al., 1997). They recognize the communication gap that language causes in their relationship with their patients and its effect on care provision.

It seems that IMGs' familiarity with the language expressions used by the local cultures is important in maintaining appropriate communication with patients (Dahm, 2011, Jain and Krieger, 2011, Slowther et al., 2012). Patients' cues, for example, idioms such as "tossing and turning", were not acted upon in Dahm's (2011) observation because the physician was a non-native English speaker. Furthermore, IMGs in Slowther et al. (2012) recognized that difficulty in communication could result from misunderstanding eye contact, tone of the voice and gestures, which cannot be tested in a standard English language test.

Additionally, patients' local dialects were found to be an ongoing challenge even with IMGs' optimal communication and language skills. IMGs in Dorgan et al's study (2009) had difficulties understanding their patients because of their southern dialect in the region of Appalachia, US. Similarly, participants in McDonnell and Usherwood (2008) found that accent, in addition to speed, volume and jargon used by Australian patients may add further complications to the IMG-patient communication process.

Moreover, IMGs seemed frustrated by their inability to build a relationship with their patient that is based on trust and satisfaction because of the language barrier (Fiscella et al., 1997, Zeighami et al., 1978). Jain and Krieger (2011) looked at strategies employed by IMGs to overcome the language barrier. They found that some IMGs repeat information, keep conscious eye contact and learn patients' dialect to try to compensate for linguistic differences (Jain and Krieger, 2011).

In general, language discordance between physicians and patients, in addition to dialects and accents may act as barriers to quality care.

3.4 Cultural competence in Saudi Arabia

The final body of literature in this review focused on cultural competence in SA itself. Al-Ahmadi and Martin (2005) carried out a systematic review to investigate the quality of primary health care services in SA, based on access and clinical and interpersonal effectiveness. They included 31 articles, which covered the Western, Central, Eastern, Northern and Southern regions of SA and differed in their methodologies and focus. The authors mainly found cross-sectional surveys and retrospective records review types of studies that examined the quality of primary health care services. They found a significant variation in the quality of primary health care services: for example, good

access was reported to vaccination programmes and prenatal care, while access to programmes targeting chronic health conditions was found to be below the target (AL-Ahmadi and Martin, 2005). Five of the studies focused on assessing the quality of interpersonal aspects of care through examining patients' satisfaction with communication and exchanging information with their physicians. The studies identified poor patient satisfaction in terms of interpersonal care, which was described in terms of language and cultural differences between the majority of IMG primary health care physicians and local patients. However, none of the studies included attempted to attain a qualitative understanding of the issue of language and culture in interpersonal care.

3.4.1 Saudi based literature in regards to cultural competence

There is very little research investigating the status and experiences of international health workers in SA. Despite researchers' acknowledgement of the critical situation of cross-cultural care provision by expatriate nurses (Aldossary et al., 2008, Mutair et al., 2014, Luna, 1998) and physicians' (Searle and Gallagher, 1983, Elzubier, 2002) in SA, most publications found were review papers that presented the challenges faced by international health workers, from the authors' perspective. In addition, these papers acknowledged the importance of cultural competence training in the provision of appropriate health care to local patients and explained the situation, as well as calling for solutions.

Although IMGs dominate the physician workforce in SA, previous research has been directed towards international nurses whose numbers, compared to IMGs, are noticeably decreasing (64% and 50% in 2008 and 2012, respectively, of the total nurses working under the MOH) (MOH, 2012).

One qualitative study was found concerning international nurses' experiences in caring for Muslim/Saudi patients (Halligan, 2006). The study involved six non-Muslim critical care nurses' experiences in caring for Muslim patients. The nurses involved were from Australia, UK, Canada, Ireland and India.

Levels of appreciating local Muslim patients' religious needs, in this study, varied. For example, while some nurses kindly assisted patients in performing their prayers by positioning them in the direction of "Kaba", others got frustrated when patients needed this kind of assistance, as they believed that the patients were too sick to move (Halligan, 2006).

The nurses in Halligan's (2006) study used terms such as "frustrating" and "stressful" to describe some of the situations where they had to deal with local patients' customs and beliefs which were different from their own. For instance, they thought that it was not convenient for them and for the patients to have a large number of visitors surrounding the bed. Additionally, they disliked the fact that visitors stayed for a long time and brought coffee and food for the patients and for themselves to consume during their visit, although the participants were aware that these customs are part of the Saudi culture (Halligan, 2006). The nurses were also frustrated by Saudi doctors following patients' wishes, a course of action which they believed was often not in the best interests of these patients. For example, the parents of a boy who had 80% third degree burns refused to medicate their son and the doctor followed their wish.

The nurses in the study by Halligan (2006) were irritated by behaviours that are deeply rooted in the religion and culture of local people. They also felt "powerless" in terms of providing health care for local patients. Thus, it was interesting to find that the nurses

felt obliged to suppress their opinions and feelings and function in a detached manner, focusing only on the physiological needs of the patients. This behaviour may have had a negative influence on patient safety, as it missed essential factors in delivering quality care, such as relationship, rapport and emotional support, even if patients were satisfied with this kind of care.

The situation was complicated by language discordance, which was acknowledged by the nurses as a significant challenge to communication. The nurses thought that they were in "a constant battle to be understood". To provide appropriate care they needed to be engaged in lengthy conversations with the patients, which ideally should have involved descriptions and expressions of feelings. The nurses in the study were not able to understand long sentences and depended on facial expressions and gestures to understand feelings. In response to patients' discourse, they smiled at the patients as a mechanism to maintain trust, yet they believed that no trust can be built with patients if communication is poor.

It should be noted that the nurses in this study may not be representative or typical of expatriate nursing staff in SA. The author implied that the nurses received Arabic language courses and, as noted, the majority came from the Western world, indicating that the study was conducted in a tertiary care hospital.

Younge et al. (1997) published a review paper on communication with cancer patients in SA. They were interested in communication in general; however, as the international health workforce is dominant in SA, they noted that:

"*the commitment to continuing care with proper communication that is required for the whole of medicine is likely to be fully realized only when the majority of the workforce are Saudi nationals*" *(Younge et al., 1997, p.315)*

In this statement, "continuing care" related to the high turnover rate among international health workers in SA. In addition, the use of the expression "proper communication" might reflect their belief that culturally competent communication cannot be acquired through training by international staff. A similar observation was noted in Aldossary et al. (2008) who reviewed the development of nursing with the current challenges in SA. They concluded that:

"*The challenges for Saudi Arabia are increasing its proportion of indigenous nurses who will be able to deliver culturally appropriate high quality care and to share the Arabic language of their patients. Without this, it may prove difficult to deliver effective health education within nursing work*" *(Aldossary et al., 2008, p.128)*

As health care provision and patient education are duties shared by nurses as well as primary health care physicians, this statement may challenge the effect of cultural competence training. It may also provide a solution which is hard to achieve, given the situation in SA, where the demand for health care exceeds the supply of local GPs.

In 1998, Luna, a nurse who worked in a tertiary care hospital in SA published a review paper suggesting educational programmes for international nurses, based on her own experiences. She stressed the importance of introducing effective trans-cultural educational programmes designed for international nurses, as she recognized the challenges in providing care to Saudi patients who do not share the same belief system.

In her paper, she focused on the concept of cultural competence in terms of its significance, applications and challenges, and proposed some strategies to educate international nurses using SA as an example, rather than a unique setting that needed more specific investigation (Luna, 1998).

 A review paper was published more recently which aimed to raise awareness among international nurses and to improve their understanding of culturally competent care from the Saudi perspective (Mutair et al., 2014). In this paper, Mutair et al. (2014) provided an information base that allows nurses and all international health care providers to have a general understanding of the Saudi culture. They focused on the nature of the family unit in SA, and confirmed the importance of this unit, as well as calling for a family-centred model of care, as a cultural requirement. The authors' call for this type of care was based on their observations and analytical thinking, but patients' comments regarding their actual needs were not discussed or investigated in the paper.

The issue of cultural competence in SA has been overlooked, despite the dominance of IMGs in the healthcare workforce. The Saudi-based research has highlighted the existence of the challenges proposed by cross-cultural care; however, only one study has investigated cross-cultural care among international nurses, with no studies considering the role of IMGs or patients' needs in this regard.

3.5 Summary

While there are many studies that have considered immigrant patients' and local physicians' experiences of the cross-cultural medical encounter, there are a limited number of studies that have looked at the reverse scenario, where IMGs care for local patients. These studies reveal challenges that considerably affect the quality of care

provision. Although it has been noted that the majority of these studies did not actually use the term "cultural competence", this concept clearly exists, as cross-cultural medical communication is the central idea examined in these studies.

It has been shown that the quality of interpersonal level of care in SA is suboptimal. Additionally, there is a lack of studies investigating IMGs' experiences of caring for local patients in SA, despite researchers' acknowledgment of the existence of cultural challenges in providing appropriate health care by international health workers and despite the existence of evidence that prove that cultural competence training has positive effect on physicians' attitude and patients' satisfaction.

Chapter 4

Scope of the study

4.0 Introduction

This chapter outlines the study rationale, based on key points identified from the literature review and on the specific situation of the Saudi MOH which is working to improve primary health care services, while the quality of care was shown to be suboptimal, particularly for chronic disease management including health education and interpersonal communication. Exploring IMGs' experiences in caring for local patients is under-researched. The previously identified challenges and facilitators experienced by IMGs in caring for local patients in different parts of the world may differ from those that could be identified in SA due to its different cultural and social structure. This chapter discusses the rationale for exploring IMGs' experiences in caring for T2DM patients and the experiences of the latter in receiving care from IMGs, in SA. It then articulates the research aims and objectives.

4.1 Study Rationale

One of the main goals of the Saudi MOH is to decrease the load on hospitals and focus on promoting health and preventing diseases through primary health care services. The MOH in SA is giving particular attention to developing primary health care provision, and is spending huge amounts of money to this end. This is evident from the dramatic increase in the number of PHCCs. This had led to more availability of GP positions, which cannot be filled by Saudi physicians. As a result, the country has had to rely on IMGs to satisfy the increasing demand for primary health care provision.

Meanwhile, the literature, presented in the previous chapter, provides evidence that IMGs are faced with culturally-related challenges that negatively affect the quality of care with which they provide local patients. In line with this evidence, a systematic review examining the quality of primary health care in Saudi Arabia by Al-Ahmadi and Martin (2005) showed poor quality of care at the interpersonal level, which is mainly provided by IMGs in SA. The search in the literature showed no attempt to further examine the exact reasons behind this poor interpersonal level of care; however, the authors acknowledged that this could be attributed to cultural differences between most IMGs and patients.

The previous chapter identified the fact that IMGs' challenges in interacting with local patients are underexplored. There is not enough evidence concerning IMGs' experiences of interaction with local patients, nor is there any great understanding of these experiences. Furthermore, researching the literature highlighted the lack of studies comparing the accounts of IMGs and local patients to present a comprehensive picture of the situation. A close look at how IMG-local patient interaction affects patients'

perception of physicians' advice, which needs to be culturally sensitive, has not been carried out yet.

It was discovered in the previous chapter that cultural competence interventions have proved their effectiveness in improving the quality of care, through improved patient satisfaction and physicians' confidence in terms of being able to provide patients from different cultural backgrounds with care. However, the relationship between IMGs and patients is more complex than the one that exists between local physicians and immigrant patients, due to the dominance of patients and the vulnerability of IMGs. Thus an in-depth qualitative approach to exploring IMGs' and patients' experiences seems important.

IMGs' and local patients' experiences in caring for T2DM were included in the current study to highlight these experiences, as it is an example of a situation where competent physician-patient communication is essential because physicians are required to explain the diagnosis, its consequences, its medications, their use and side effects. T2DM is an important public health issue; patients with T2DM require long-term follow-up and need to be educated by GPs. What is more, this disease is highly prevalent in SA and requires lifestyle changes, which are culturally defined. IMGs are relied on heavily to provide diabetes care, and they are expected to provide culturally sensitive lifestyle advice to local patients in order to help them to control their condition. However, the MOH has not yet fully grasped the challenges IMGs face as they endeavour to provide high quality care.

Given that the MOH in SA aims to strengthen its primary health care system, and that SA is one of the countries with a majority of IMGs (Arabic and non-Arabic speakers) little is

known about IMGs' and their patients' experiences. This study aimed to examine the issue of cultural competence by exploring IMGs and patients' experiences in the cross-cultural medical encounter.

Exploring the challenges faced by IMGs in caring for patients with T2DM could lead to recommendations to reduce these challenges and ease the interaction process between physicians and patients in cross-cultural clinical settings in order to provide T2DM patients with high quality care.

4.2 Research questions:

- What does the interaction between IMGs and local patients with T2DM look like in SA?

- What are the barriers faced by IMGs in delivering effective diabetes care to patients in SA?

- What are the strategies and facilitators used by IMGs to deliver effective diabetes care in SA?

4.3 Study aim

To elicit in-depth information from IMGs and local patients with a view to providing recommendations to feed into SA policies relating to public health and IMG training.

4.4 Study objectives:

- Identify and recruit a sample of IMGs from hospital-based and community-based primary health care clinics.

- Identify and recruit a sample of T2DM patients from hospital-based and community-based primary health care clinics.

- Obtain a general understanding of the issue under investigation by conducting a focus group discussion with hospital-based IMGs.

- Analyse findings from focus group discussion to inform the development of a topic-guide for in-depth interviews with IMGs and T2DM patients.

- Conduct in-depth interviews with IMGs to elicit their experiences of interacting with patients and their perceived role in treating T2DM patients.

- Conduct in-depth interviews with Saudi patients with T2DM to explore their perceptions of IMGs' role in caring for their condition, and the advice given by these physicians.

- Use thematic analysis to draw out key findings from the data.

- Use the findings to draw up recommendations to improve the quality of physician-patient interaction in T2DM care in SA.

Chapter 5

Methods

5.0 Introduction

This chapter describes the study methodology and methods developed to explore the research questions outlined in Chapter 4. A discussion of the researcher's epistemological position, decisions made regarding methodology, and methods proposed, is provided in this chapter.

A focus group discussion and face-to-face semi-structured interview techniques were chosen to obtain an in-depth understanding of the experiences of and possible facilitators and barriers to effective communication between IMG primary health care physicians in SA and the patients they care for with T2DM.

For a deeper exploration of the issues under investigation, data were collected in three phases from two different sources, i) IMG primary health care physicians and ii) Saudi patients with T2DM. Phase 1 involved a focus group discussion with IMGs from one hospital-based primary healthcare clinic, and semi-structured interviews with IMGs from eight community-based PHCCs. This was followed by phase 2, which involved semi-structured interviews with Saudi patients with T2DM from the hospital-based clinics and the community-based PHCCs. Phase 3 involved follow-up interviews with some of the IMGs for further exploration of issues raised by both IMGs and patients.

5.1 Research perspective

How do we understand reality? What is our relationship to it? And how can we find out about it? These questions are referred to as the ontology, epistemology and methodology of a piece of research. Responses to these philosophical questions inevitably shape the way in which research is conducted, as well as the assumptions made about the data generated.

There are two main ontological positions: realism and relativism (Bryman, 2008). Realists or positivists assume that there is one external reality that can be accessed directly by researchers to produce definite knowledge. By contrast, relativists assert that there is no independent reality, and that people construct their own reality through interpretation (Bryman, 2008). Between the polarised dichotomy of realists and relativists, subtle realism asserts that there is an underlying reality, which can be studied, however the data generated to reach that reality is influenced by subjective interpretations of the participants (Hammersley, 1992). This can be further influenced by the researcher's interpretation of the respondents' accounts.

The current study is logically connected with the subtle realism philosophy, which was convincing because people having different perspectives emphasises the fact that they give different meanings to everyday reality. Furthermore, the belief in the existence of an independent reality acknowledges the fact that for reasons beyond their control, people experience and perceive reality differently.

Constructivism is the major epistemological approach for qualitative research. Constructivists believe that the world is complex and subjectivity in interpreting social realities does exist (Bryman, 2008). Furthermore, constructivists believe that people are

surrounded by social realities, which are difficult to measure statistically. Social research is characterized by the interaction between the researcher and the study participants, which inevitably influences the study's findings (Silverman, 2010, Hammersley and Atkinson, 2007). Snape and Spencer (2003) explain what is meant by constructivism as follows:

"displaying multiple constructed realities through the shared investigation by

the researchers and participants of meaning and explanations" (p. 12)

The researcher's role is understanding how meanings are given to reality through peoples' interaction (Guba and Lincoln, 1994). Qualitative researchers believe that each individual is unique, and to understand them, the researcher should talk to them, listen to them and observe them in their natural setting (Guba and Lincoln, 1994).

Based on a constructivists' position, qualitative research aims to answer questions such as 'what', 'how' and 'why' of a phenomenon from the participants' accounts rather than the researcher's point of view. Although the researcher should strive to represent the respondents' own interpretations as faithfully as possible, he or she should acknowledge that they add a further layer of interpretation in terms of their own research focus and theoretical insights.

 Entering the research setting with a set of stated hypotheses may lead to failure to discover the real nature of the phenomenon. This is true because adherence to hypotheses may keep the researcher away from seeing the research findings in a broader sense and may interfere with the participants' experiences of a particular phenomenon (Spencer et al., 2003).

Qualitative methodology was chosen for this research because meeting the aims of this study requires an in-depth understanding of the circumstances, experiences and perspectives of IMGs and T2DM patients themselves in communicating and interacting with one another. A further reason for choosing this methodology is the nature of the output sought from the research, as this study provides a detailed analysis and offers interpretation of cultural-related issues, which are difficult to explore quantitatively. Furthermore, as one view of reality is believed to be obtained through individuals' eyes (Snape and Spencer, 2003, Silverman, 2010), this study explores questions such as: what is there that can be known about experiences and communication between physicians and patients in cross-cultural clinical settings? Why does a relationship take a certain form? How does this affect care for patients with T2DM as perceived by IMGs and patients in SA? These kinds of questions are better explored using qualitative methodology (Bryman, 2008, Silverman, 2010). The complexity of the subject matter was accepted in advance, as this was evident from the academic literature (discussed in 3.3) dealing with cultural competence and communication in cross-cultural medical settings and in managing chronic health conditions such as diabetes. It is important that the researcher conveys a complete picture, as far as possible, of this complexity (Snape and Spencer, 2003).

5.1.1 Techniques of qualitative data collection in the current study

5.1.1.1 Focus group discussion

A focus group is a small group of people who are brought together to discuss a specific issue. This group is usually directed by a facilitator who leads the discussion and proposes the broad topic areas to be discussed (Green and Thorogood, 2014). The key

aim of using a focus group discussion is offering the opportunity for interaction between participants. Focus group discussions are characterized by using group interaction as part of the method, allowing participants to respond to each other's views and probe each other's reasons for holding a certain view (Kitzinger, 1995). Furthermore, focus groups offer the opportunity to study how individuals collectively make sense of phenomena (Bryman, 2008).

In this study, the focus group consisted of physicians who already knew each other and may have shared similar work experiences. This was considered a positive point as it maximised interaction between the discussion group members and with the group facilitator. The focus group discussion served as a "brain storming" session to help identify key issues in IMGs' experiences. Data arising from this interaction were then used to develop key issues in the topic guide for semi-structured interviews.

Practical challenges to conducting focus group discussions are not uncommon. For example, it can be difficult to organise a focus group as getting people to gather at one time in a certain place is challenging (Bryman, 2008). In the current study, the initial focus group discussion was conducted with hospital-based IMG family physicians because gathering together physicians, who usually have busy schedules, from a hospital, was considered more practical than recruiting them from different PHCCs.

Encouraging potential participants to attend by offering incentives such as travel reimbursement, a gift voucher from a bookstore or refreshments is considered to be ethical as long as the rewards are not seen as inappropriate or coercive. For example, in the current study, a voucher of 100 Saudi Riyals (20 GBP) from a well-known bookstore

was distributed to all the IMGs who were interviewed in return for their time and contribution to the research.

Transcribing data from focus group recordings is challenging because the transcriber needs to differentiate between participants and be familiar with "who said what" (Bryman, 2008). Analysing data from a focus group discussion can be time consuming and it has the potential to quickly produce a huge amount of data (Bryman, 2008). Furthermore, as cross-talk is common among groups, more inaudible elements can be found in the recordings compared to other methods of data collection (Bryman, 2008). However in this study, as the researcher was the one who collected, transcribed and analysed the data, it was possible to overcome most of the challenges mentioned previously.

5.1.1.2 Semi-structured interviews

This study used qualitative, semi-structured interviews as the main method of data collection. The qualitative interview is a rich source of data. It has been noted that:

> "The expressive power of language provides the most important resource for accounts. A crucial feature of language is its capacity to present descriptions, explanation, and evaluations of almost infinite variety about any aspect of the world, including itself" (Hammersely and Atkinson, 1995, p.126)

Semi-structured interviews can be viewed as a way to gain access to the knowledge, experiences and feelings of interviewees, and as an interactive process where the interviewer probes to gain more details and aims to go below the surface to uncover ideas that were not anticipated (Legard et al., 2003, Britten, 1995, Silverman, 2010). As the majority of studies identified in the SA based literature were quantitative, and a

qualitative approach had not been attempted before in SA to explore IMGs' experiences, both approaches were combined to access the knowledge and experiences of participants using open-ended questions and allowing probing to explore issues in-depth.

Using semi-structured interviews offers the interviewer and participants privacy in managing uncomfortable issues, building rapport, clarifying thoughts on a particular topic, sharing enthusiasm and airing complaints (Bryman, 2008). In the current study, IMGs' and patients' views on each other and on the service could be explored. It was anticipated that both positive and negative views may be expressed, which were better explored in the private setting offered by semi-structured interviews.

It should be recognised that data generated through interviews are influenced by the methodology as it is

> "*highly dependent upon people's capacity to verbalise, interact, conceptualise and remember', thus the 'constructed' nature of the generated data can never be taken as a direct representation of people's understandings outside the interview context*" (Mason, 2002, p.64).

This closely follows a subtle realist stance which emphasises that the researcher's task is to 'represent' rather than 'reproduce' reality. It is impossible to deny the effect of the social interaction between the interviewer, interviewee and the interview context on the produced data. As mentioned earlier, the researcher should reflect upon this complexity rather than assuming taking a neutral role in data collection.

5.1.1.3 The approach of this study

The interview approach for this study included combining structure with flexibility, taking into account the interactive nature of the interview and picking up on things said

by interviewees which were not included in the topic guide (Legard et al., 2003, Bryman, 2008). Additionally, the subjective nature of each individuals' account was acknowledged, as the aim of this research was to provide a fair representation of participants' meaning and to emphasise how each interviewee framed and understood the issues (Bryman, 2008).

The focus group discussion was employed to help in identifying the main issues in IMG-patient experiences of care provision. Issues arising from the focus group helped in developing a topic guide for the semi-structured interviews, during which more sensitive issues could be probed, because information was not shared with other IMGs, as was the case in the focus group discussion.

Semi-structured interviews and a focus group were chosen as methods to collect data for this study, rather than participant observation. Participant observation has the advantage of offering data from "natural settings" rather than setting up an "artificial" environment like an interview. However, its sole use could be biased by only reflecting the observers' perceptions of the data (Mays and Pope, 1995, Bryman, 2008, Silverman, 2010). Thus, observational methods are typically used in combination with other sources such as interviews (Bryman, 2008). Whilst acknowledging that different, yet still relevant data would have been generated by observing consultations, this method was excluded in this study, because Hawthorne effects might be prominent in observational studies (Bryman, 2008, Eckmanns et al., 2006). For example, physicians and patients may change their behaviour as a result of the presence of the researcher during the medical consultation. Perceptions, issues regarding feelings, and the effect of cross-cultural consultations on patients' lifestyles are less likely to be elicited by observing medical consultations.

Additionally, the effectiveness of interviews in detecting culture-related issues had already been studied and identified (Fiscella et al., 1997), and similar previous studies, on different populations, were conducted using the same technique (Dorgan et al., 2009, Fiscella et al., 1997, Jain and Krieger, 2011). Furthermore, hearing the participants' voices and responding to their needs can lead to more appropriate recommendations to improve the service (Silverman, 2010).

5.2 Topic guides

Semi-structured interviews and focus group discussions consist of a schedule of open-ended questions to guide interviewers through the issues under investigation. Prompts are then used in order to elicit more detail and these might diverge according to the responses given during the interview (Britten, 1995, Bryman, 2008). Probing responses of the interviewee offers understanding beyond that of superficial questioning (Legard et al., 2003). Examples of probing include, "How did you feel about that" /"Can you tell me more about that" and so on. The current study used topic guides that were based on the key themes arising from the literature which were relevant to the research questions. This created a systematic flow and allowed spontaneity in questioning, with the researcher prepared to alter the order and sometimes the wording of questions to follow the emerging ideas during the actual interview (Arthur and Nazroo, 2003). The topic guide ended with an open question to enable areas that were not anticipated from previously researched IMGs' experiences as described in the published literature.

5.3 The role of the researcher in qualitative research

As mentioned in 5.1, the researcher's role in qualitative research is understanding how people give meaning to reality through interaction (Guba and Lincoln, 1994). Green & Thorogood (2004) have suggested that there are two types of perspectives that may influence the findings produced as a result of qualitative research. The emic perspective, or the insiders' standpoint, is when the researcher is a member of the culture or the group and hence is familiar with the culture being studied. In contrast, the etic perspective, or the outsiders' standpoint, is when the researcher is not familiar with or not a member of the culture under investigation. If the researcher is part of the culture under investigation, he or she may be able to bring more knowledge, as they are more familiar with expressions, sentiments, ways to communicate and establishing rapport (Green and Thorogood, 2014). At the same time, being an outsider may enable the researcher to look at participants' experiences with a fresh pair of eyes without preconceived assumptions. More specific issues in regards to researcher's reflexivity is discussed later in this chapter (see section 5.8.4)

5.4 Transcription and translation

People who speak different languages perceive and interpret the world differently (van Nes et al., 2010, Temple and Young, 2004, Tsai et al., 2004). Furthermore, the evidence for the experiences discussed, gathered from the interviews, is indirect evidence. This means, for example, that this evidence does not feature the interviewees' own words, but the ideas, thoughts and meanings of people's accounts, which are produced in the form of texts (Polkinghorne, 2005). Studying human experiences is a challenging area, as experiences are usually multi-layered and complex (Polkinghorne, 2005). Translation

can add to the complexity of producing valid findings. As data in this study were collected from patients and Arabic-speaking IMGs in Arabic and were translated to produce findings in English, the preservation of meanings originating from the data in the source language could be at risk (van Nes et al., 2010). Issues that arose during the transcription and translation of data in the current study are presented later in this chapter (see section 5.7.3).

5.5 Methods

5.5.1 Ethical approval

Before recruitment and data collection, ethical approval was obtained from the School of Health and Related Research (ScHARR) Ethics Committee and the Saudi Ministry of Health Institutional Review Board (Appendices 3 and 4). The researcher passed a web-based training course "Protecting Human Research Participants" in order for the application to be approved by the MOH (Appendix 5). A letter of approval was obtained from the Head of the Family Medicine Department at the King Khalid University Hospital (KKUH) to conduct the focus group and approach patients from the hospital (Appendix 6).

5.5.2 Study design

The qualitative research design included three main phases (Figure 5.1):

Phase 1: This encompassed two methods of data collection:

1) Focus group discussion with IMG family physicians from hospital-based primary healthcare clinics.

2) Semi-structured interviews with IMGs from community-based PHCCs.

Phase 2: This encompassed:

1) Semi-structured interviews with Saudi patients with T2DM attending community or hospital-based primary health care clinics.

Phase 3: Encompassed:

1) Further follow-up interviews with IMGs.

Phase 1

Focus group discussion with hospital-based physicians

Identify initial key issues and develop topic guide for interviews

Follow-up interviews

Interviews with community-based physicians

Phase 3

Develop topic guide for patient interviews

Responses need further exploration by physicians

Interviews with patients from hospital and community clinics

Phase 2

Responses fully explored

Figure 5.1   Overview of the research process

An iterative approach was adopted to allow each stage to inform the next.

The focus group and the semi-structured interviews were conducted over a period of nine months in 2012/2013. An additional month was needed to conduct the follow-up interviews.

5.5.3 Study Settings

This study was conducted in the capital city of SA, Riyadh. It is located in the central region and is one of the biggest multicultural cities in the country.

5.5.3.1 King Khalid University Hospital

The KKUH was specifically selected for the study because most family physicians in this hospital are non-Saudi IMGs. It is a secondary care hospital that serves a large segment of the population, including patients from a range of socio-economic circumstances. Furthermore, the KKUH was chosen for practical reasons, which include the researcher's familiarity with the hospital and its systems.

The primary healthcare clinics at the hospital are located in a new building, which also houses clinics dealing with other specialised areas of medicine. The hospital and the University staff are seen, as patients, in another two different clinics within the same building. The same physicians are working in rotation around the three different clinics. Male and female waiting areas are on different sides of the building, although they are close to each other. Male physicians treat male patients, and female physicians treat female patients. In case of a shortage of female physicians, male physicians are allowed in the female section to see female patients, however the opposite is not permitted.

Patients who visit the hospital-based clinics do not expect to see the same physician each time they visit the clinic because physicians rotate between clinics on a regular basis.

5.5.3.2 Primary Health Care Centres

The Saudi MOH has already started to standardize the design of all PHCCs. A large number of PHCCs look like the centre shown in figure 5.2.

Figure 5.2 Exterior view of one of the PHCCs in SA

Each centre has two entrances, one for males and another one for females. The two sections are connected from the inside by a window to facilitate exchange of documents. One male manager, working with the help of a female supervisor from the female section, is responsible for each PHCC.

Each PHCC has three to four physicians, depending on the community it serves: a paediatrician and two or three general practitioners. Two different days of the week are specified by each PHCC to see patients with chronic diseases. Additionally, there is one qualified nurse for antenatal care.

The KKUH and the PHCCs provide free services for Saudi nationals and, with some restrictions, to non-Saudi nationals.

If equal distribution of physicians and patients throughout all community-based PHCCs is assumed, then three general practitioners are assigned to each clinic, with each clinic serving approximately 10,000 patients (MOH, 2012). There is no available data regarding socio-economic status. Based on local knowledge, however, different regions can be identified which represent different socio-economic levels. North and East of Riyadh City represent middle to high socio-economic levels and South and West represent lower socio-economic levels.

Community-based PHCCs were recruited according to the socio-economic level of the community they serve: high/middle and low. The clinics were identified from the website of the Saudi MOH by searching clinics by neighbourhood (MOH, 2011). Four clinics from each socio-economic level were selected based on the researcher's knowledge of the region.

The manager of each clinic was contacted by telephone or personally to explain the study, seek approval and gain information relating to the physicians working at the PHCC. If the manager of the clinic either did not agree to allow the researcher to conduct the study in his PHCC, or did not respond to the researcher's phone calls, or if no IMGs were found, another PHCC from the same region was contacted (Figure 5.3).
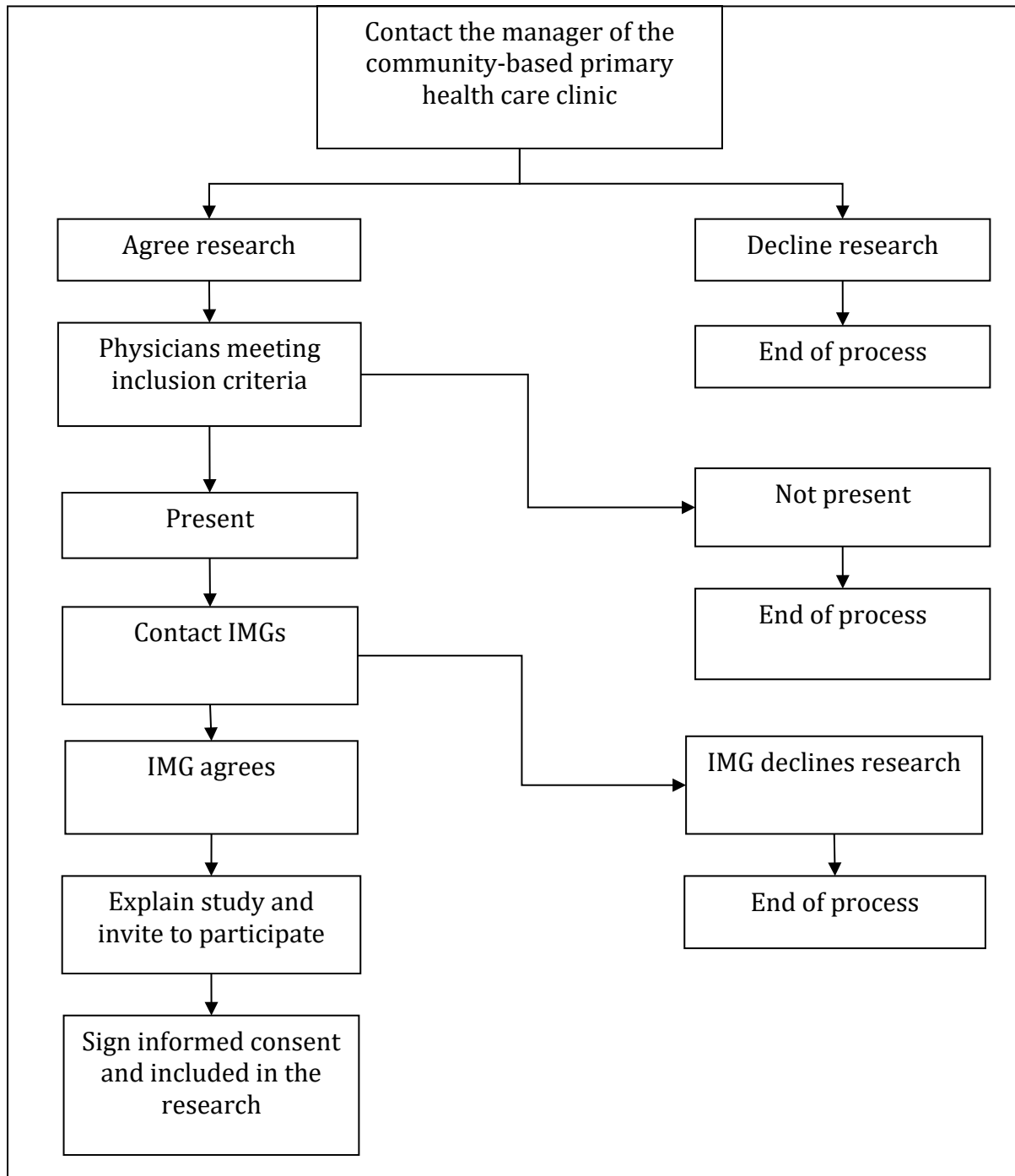
Figure 5.3 Recruitment and consent process

5.5.4 Phase 1

5.5.4.1 Sampling and recruiting IMGs

5.5.4.1a Hospital-based IMGs

IMGs from the hospital were invited to a focus group discussion by email. The information sheet and consent form (Appendix 7 and 8) were attached to the emails sent, which were circulated on behalf of the researcher by the secretary of the Department of Family Medicine to all IMG family physicians who were available during the recruitment period. The information sheets provided described the aims and objectives of the study as well as explicitly stating, both that participation was voluntary, and that a potential participant's decision regarding whether to participate or not would not affect their work. Purposive sampling was used to ensure a wide range of characteristics was represented in the group. Characteristics included different age groups (<40 and >40), gender, and length of experience in SA. IMGs were invited to participate if they had at least two years' experience of working in SA to ensure a reasonable amount of interaction with Saudi patients.

Sufficient time was given to the participants to read and understand the information sheet and to decide whether to participate. IMGs from the KKUH were explicitly asked to be involved in a focus group discussion where other IMG participants would be present.

IMGs who were interested in participating were asked to contact the researcher by email or by telephone or pass their details to the secretary of the Department of Family Medicine at the KKUH. After one week, the secretary of the department circulated follow-up emails to those physicians who had not responded. The researcher, then, approached IMGs personally to talk about the research.

Twenty-one of the total of 28 family physicians working at the KKUH were IMGs, of whom seventeen IMGs were available in July 2012. The IMGs who were available were invited by email through the department secretary with a view to bringing together 10 – 15 participants. This range of participants was chosen as it would be manageable for the researcher and at the same time could allow variations in responses. The researcher visited the clinic twice and re-invited the IMGs who were available at the time of her visits.

5.5.4.1.b Community-based primary health care IMGs

The researcher was asked by all the recruited PHCCs' managers to personally approach the IMGs. The researcher visited each clinic to develop a rapport with the IMGs who were interested in participating. The researcher provided the IMGs at the PHCCs with information sheets (Appendix 9). IMGs were asked by the researcher to contact her by telephone or email if they agreed to participate after they were handed the information sheet. The researcher re-visited the same PHCCs after one week to remind the IMGs about the study, answer their questions and arrange interview times. Potential participants were offered a choice of face-to-face interview or telephone interview.

It was intended to recruit approximately 7 – 10 IMGs from PHCCs in the two different socio-economic levels. Flexibility was allowed to decrease or increase the sample size according to data saturation.

As with the focus group, purposive sampling was used to ensure maximum diversity. IMG participants differed in terms of gender, age and years of experience.

5.5.4.2 Data collection

5.5.4.2.a Focus group with hospital-based IMGs

Physicians from the hospital who had agreed to participate were invited to a focus group discussion that was led by the researcher. Consent forms were signed and demographic data were collected at the beginning of the focus group (Appendices 8 and 10).

Before obtaining any written consent, participants were asked whether they had read and understood the purpose of the study and what it entailed. They were also asked if they had any queries concerning their participation.

The focus group discussion was recorded using a small Dictaphone and it was conducted in English. It was explained to the participants that they had the right to ask the researcher to stop the recording before the focus group discussion or at any time during its progress.

The focus group took place in the Family Medicine Department's seminar room and lasted 65 minutes. Before starting the discussion, it was made clear to the IMGs that their withdrawal from the study was allowed at anytime without any implications for their work.

To avoid distractions during the discussion, the researcher arranged with a fourth year medical student to handle late arrivals, collect the forms and take notes.

As two IMGs were happy to participate, yet not available at the time of the focus group, they were individually interviewed using the topic guide used to guide the focus group discussion (Appendix 11).

5.5.4.2.b Semi-structured interviews with community-based PHCCs' IMGs

Interviews with the community-based IMGs took place at the PHCCs they worked at, or by telephone. Each interview started with obtaining demographic information about age, gender, nationality, and years of working in SA (Appendix 10).

Interviews followed a topic guide (Appendix 12), and were conducted in English for non-Arabic speaking IMGs. The Arabic-speaking IMGs were given the choice of English or Arabic and all preferred to be interviewed in Arabic. For culture-related reasons, only female IMGs from the PHCCs, and female patients, were asked to choose the place in which they were comfortable with being interviewed.

The length of the interviews ranged from 35 – 55 minutes. The researcher sought agreement from the IMGs about the feasibility of re-contacting them for another interview, should the need arise.

Field notes were taken by the researcher during and after each interview to enable reflection and support data analysis (Legard et al., 2003).

5.5.4.3 Topic guide

Topic guides for this study were developed based on the topic guides of previous, similar studies (see section 3.3.1) (Dorgan *et al*., 2009; Díaz and Hjörleifsson, 2011; Jain and Krieger, 2011), and amended according to the research questions for this project. The topic guide for the focus group discussion covered IMGs' perceived roles in caring for patients with T2DM, challenges to providing care and suggestions to support their contribution in caring for Saudi patients in particular (Appendix 11). The focus group discussion helped identify key issues, which fed into the topic guide for individual interviews.

Topic guides for the semi-structured interviews with IMGs covered these issues in more detail (Appendix 12) focusing on areas such as how IMGs provide advice to T2DM patients, what their views on providing care to Saudi patients, and the challenges and facilitators to effective communication. The topic guide was designed in a vignette style to facilitate discussion by encouraging participants to talk about experiences, opinions and attitudes, and to express their feelings in a non-judgmental setting (Johnson et al., 2006, Greenhalgh et al., 1998). The vignette referred to fictitious characters, namely Dr. Afzal as an IMG and Mr. Ahmad as his patient (Appendix 12). Females' names, Dr. Sonia and Mrs. Aisha, were used when interviewing female participants.

5.5.5 Phase 2

5.5.5.1 Sampling and recruiting patients

The managers of the PHCCs and the IMGs advised the researcher to approach patients personally. The researcher was asked to be available in the clinic during the time of recruitment as, from their experience, IMGs and PHCCs' managers believed that patients would not be interested in contacting her by e-mail or telephone, and would probably find it more convenient to do this face-to-face.

Purposive sampling of patients was sought, with the help of the nurses, to recruit patients of different age, gender and duration of diagnosis.

The researcher distributed information sheets to patients in the Waiting Area. A private room was assigned to the researcher at the hospital and each of the PHCCs to see potential patient participants.

Individuals with T2DM were included if they had all the following characteristics:

-Diagnosed for more than two years

-Saudi by nationality and place of birth

- Over 20 years of age

Individuals were excluded if they:

-Lacked the capacity to give informed consent

-Had learning difficulties

-Had a severe mental illness

To ensure a maximum diversity sample and guarantee inclusion of patients who did not visit the clinic during the window of recruitment, physicians were asked if they could help in recruiting non-regular attendees who were known to have had T2DM for more than two years and to have poor control over their condition.

It was made clear by the researcher to all patients that whether they agreed to be interviewed or not would not have any implications in terms of the service they received.

The patient information sheet and the consent form were translated into Arabic (Appendices 15 and 16). For those who were not able to read, the researcher read through the information sheet and the consent form. Non-Arabic speaking IMGs were also given an English-language version of the patients' information sheet and consent form to ensure that they were aware of the topics discussed with their patients (Appendices 17 and 18).

5.5.5.2 Data collection

Patients were invited to be interviewed on the health care premises, or, for females, at a location of their choice, as the idea of a female researcher visiting strangers' houses is not acceptable in Saudi culture.

Participants were asked to choose a convenient time. Most patient participants suggested being interviewed immediately, at the clinic, especially female participants, who usually had to wait for the males in their families to pick them up from the hospital or the PHCC. The researcher emphasised confidentiality and stated that there would be no implications in terms of health care provision. Permission to audio-record the interview was sought and information about participants was kept confidential and not shared with their physicians.

Data collection continued until data saturation was reached. The interviews lasted 25 to 35 minutes and were directed by a topic guide shown in Appendix 13. Demographic information was collected before each interview (Appendix 19).

5.5.5.3 Topic guide

The patient topic guide, developed after the initial IMG focus group and some interviews, covered issues similar to those discussed in the IMGs' interviews, but from the perspective of the patients (Appendix 13) covering areas such as how they perceive the care, in general, and lifestyle advice provided by IMGs.

5.5.6 Phase 3

5.5.6.1 Follow-up interviews

After conducting all the primary interviews with IMGs and patients, the researcher identified some of the issues raised by the participants that required further attention. These mainly related to prejudice in the IMG-patient interaction and to IMGs'

approaches to making changes in T2DM patients' lifestyles. A further topic guide was designed to address these issues (Appendix 14).

The researcher visited the hospital personally and contacted the PHCCs by phone, to invite IMGs for follow-up interviews. All eleven IMGs from the PHCCs and three from the hospital were re-contacted.

5.5.6.2 Topic guide

Topic guides for follow-up interviews with IMGs were developed based on the issues arising from the patient interviews which needed more exploration, such as handling discrimination in the medical encounter, perceived reasons for patients not acknowledging IMGs' skills and knowledge, and reasons behind adopting different approaches to advising patients (Appendix 14).

The vignette style of interviewing was not used in the follow-up interviews because all participants found it easier to relate directly to their own experiences without the need to use the fictitious characters in the vignette.

5.6 Data analysis

Analysis of qualitative data has been described as complex because the analysis has to progress by 'moving backwards and forwards between the original data and the emerging interpretations' (Pope and Mays, 2006, p.63). Therefore the "chaotic" nature of the process of the analysis can be difficult to outline briefly. However, being transparent in terms of the process of the analysis aiming to show readers how interpretations were grounded on the data is important (Ritchie and Spencer, 1994).

After the data collection process commenced, the researcher was responsible for documenting participants' experiences, analysing the data and, most importantly, making sense of the large amount of data collected. Thus, the thematic analysis based on the grounded theory approach proposed by Ritchie and Spencer (1994) was helpful in providing a sequential structure for data analysis. The approach below describes the process of the analysis however, it simplified the complexity of the process and possibly given an artificial sense of order when in practice the process was very much iterative.

1-Familiarization:

Listening to recordings; transcribing verbatim; translating and reading and re-reading through all data. This helped in terms of gaining a holistic overview of the dataset and being familiar with the range, depth and diversity of the collected data.

2- Descriptive coding:

The computer-assisted qualitative data analysis software NVivo 10 was used for transcription and coding, which increased the efficiency of data organisation and retrieval. The researcher and the main supervisor read the same transcript and agreed on an initial coding frame which was then applied to other transcripts, with the flexibility to enable other codes to be added.

3-Basic analysis:

At this stage, emerging themes were found, along with subthemes. Data was removed from its original context and rearranged according to the appropriate thematic orientation. An example of a derived theme is given in Appendix 20.

4-Interpretation:

This was the final stage where the key themes were developed and quotations were used to provide evidence to support them. This involved exploration of the thematic network in a systematic way. Mapping the range and nature of phenomena, fully exploring each theme, creating typology and finding associations between themes were all tasks that were undertaken.

It should be mentioned that the steps of the data analysis process were not mutually exclusive, as the researcher was involved in the data analysis as soon as it was collected. Data analysis was continued throughout the study in conjunction with data collection. Analysing data in conjunction with data collection is an inevitable process as it is impossible for the researcher to not start thinking of what has been heard and seen while he/she is in the field (Pope et al., 2000). Additionally, analysing data early after entering the field was used to shape and refine on-going data collection resulting in an iterative process. Data collection and analysis were continued until theoretical saturation.

Field notes were employed to supplement recordings. Field notes on the dynamics of the focus group and the interviews, observations and reflections of the researcher while in the field and during interviews, and approaches to data collection were documented. Details provided by field notes can put the researcher in a better position to analyse the issue (Silverman, 2010). The researcher was able to compare articulated data with the data from field notes. As the researcher sought transparency in conveying meanings, participants' gestures, emotional features and contradictions between what was said by the participants and what was observed by the researcher were referred to during data analysis.

5.7 Challenges to the research

5.7.1 Ethical issues

All research studies that include human subjects generate ethical concerns. Conducting research that includes understanding people and using their voices and perceptions to generate data requires the researcher to be aware of and account for a number of ethical concerns when conducting qualitative research.

Autonomy, confidentiality and privacy are some issues that create dilemmas when conducting a piece of research that includes human subjects. Informed consent in relation to this research included discussion of the purposes, aims, objectives and potential benefits of the study to the study participants, in order to allow autonomy.

The researcher handled data confidentially. The research findings did not identify any of the PHCCs included in the study. A letter and a number were used to refer to each PHCC. The letter referred to the region in Riyadh from which the centre was selected, for example; N, E, S and W referred to north, east, south and west, respectively. The number referred to its serial number in the study - for example, N1 meant the first PHCC that was included from the northern region.

The research findings did not identify any of the participants who had taken part. Participants were numerically coded and transcripts were anonymised.

As patients were revealing personal information regarding their lifestyle and health, and as both patients and IMGs were sharing their opinions about each other, all the transcripts and records were saved on a password-protected computer and were stored securely in a locked cabinet.

Discussing a patient's condition and their interactions with IMGs could have raised some sensitive issues. The first was related to the patient's condition; for example, patients may have revealed non-compliance or misuse of their treatment. The second was related to the relationship with their physicians, for example, not understanding them, in a way that might affect their health. It was proposed that these problems should be dealt with by advising the patient to raise the issue with their physicians or with the manager/ supervisor of the PHCC, according to the nature of their complaints.

Although it was not expected that the questions would cause anxiety or stress, the nature of in-depth questioning can be stressful. Thus, participants were informed of their right to refuse to answer any question and to withdraw from the study at any time without giving any justification.

5.7.2 Challenges during recruitment and data collection

Several challenges arose during the recruitment and data collection process. The time for the focus group discussion was changed twice before it eventually took place in July 2012. During the recruitment of IMGs to the focus group, the researcher experienced difficulty in gathering physicians together at the same time, as they did not prioritise contribution to research projects. For example, two IMGs did not have a clinic on the day of the focus group and they were not willing to come to the hospital just for the sake of the discussion. Having the focus group conducted in the month of Ramadan, when people are fasting, was also a possible drawback.

Face-to-face interviews with IMGs were frequently interrupted by either colleagues from the PHCC or by patients. During some interviews, the researcher had to wait outside the clinic to allow IMGs to pursue their duties and see patients in their clinics. In other

PHCCs, the manager and supervisor referred patients to other physicians during the time of the interview.

Nurses helped in the recruitment process by advising the researcher to approach patients whom they identified as eligible. However, the researcher was advised by a nurse to approach a patient, who she later realised had hearing difficulty and thus was impossible to conduct an interview with.

It was noted that physicians, including those who agreed to assist the researcher in contacting hard to reach patients, were not collaborating in this regard and only 4 patients were recruited through their physicians. According to the IMGs, it was difficult for them to identify and select "hard to reach" patients because of the large number of patients they follow. However, they informed the researcher when patients with poor diabetes control came to the clinic so the researcher could approach these patients after they introduce the study to them.

A female patient had to leave before completing the interview, as her husband was not willing to wait until we finished. This was a shortcoming that should have been anticipated as interviews with patients were conducted at the health care premises while they were visiting their physicians.

5.7.3 Translation and transcription

In order to analyse all transcripts in one language, digital audio-recordings were transcribed by the researcher, either in Arabic or in English. She then translated Arabic transcripts into English. The translations were based on conveying meaning, as word-by-word translation from Arabic to English would not have made sense.

Loss of the meaning through translation could have threatened the validity of the study as the collected data went through three phases before it was presented to be read and interpreted by the reader
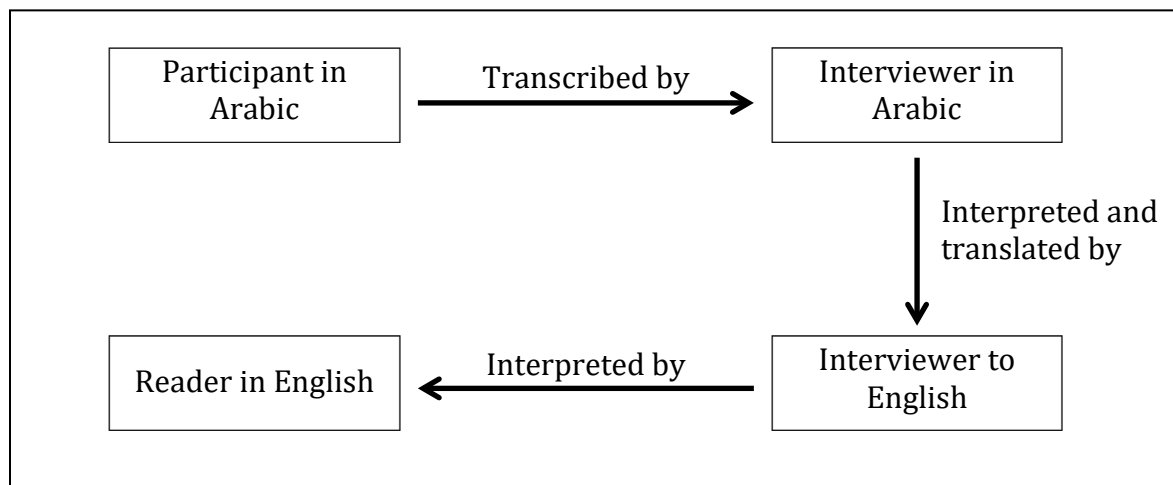
Figure 5.4 Transcription and interpretation process of Arabic interviews

Measures to reduce potential loss of meaning were undertaken. It has been argued that in order to preserve the meanings of the interviewees' accounts, the researcher should adhere to the original language as much as possible before translating it (Temple and Young, 2004). However, in this study, the researcher considered translation as a part of producing the final results of the study. The researcher was the one who collected, translated and interpreted data. She speaks both Arabic and English, and data were collected in the two different languages. For practical reasons, the data needed to be unified, so it was better to translate into the English language at an earlier stage without risking loss of meaning. Furthermore, being transparent about translation issues that

were confronted gives readers a better insight into potential loss of meaning through translation.

Interviews in Arabic were translated to English. If there was no exact meaning for one word, the researcher looked for the closest meaning in English. For example, patients used the expression "To God we complain" which is actually used by Saudi people to refer to their helplessness in dealing with their problems. If the researcher had been from a different culture, she might have interpreted this comment as patients' refusal to open up about their complaint. Furthermore, back-translation was applied to information sheets, consent forms and most of the translated transcripts (see section 5.7.3.1). Audio recordings of the follow-up interviews, which were conducted in Arabic, were transcribed immediately in English.

It should be noted that interviewing physicians of different ethnic backgrounds might have uncovered different approaches to knowledge and experiences that would be described by non-Arabic speakers using English, their second language, and received by the researcher, who also speaks English as a second language. To keep the risk of loss of meaning to a minimum, adequate probing of the issues and the iterative approach of study were applied.

5.7.3.1 Back-translation

Back-translation was needed to ensure transcripts were appropriately translated. Interviews were sent to a professional translation service in Riyadh. Two Sudanese translators worked in the centre. They shared the Arabic language with the researcher and the patient participants, but not the cultural background. However, the researcher

was able to assess their translation and convey what she saw as being closer to the real meaning if this had not been achieved.

Going through the back-translated texts helped the researcher to compare texts and point out some of the weak points in her own translation. For example, the researcher used "IMGs" on different occasions where participants actually used "اجانب اطباء" "foreign physicians", "وافدين أطباء" "expatriate physicians" and "متعاقدين اطباء" "contracted physicians" to refer to IMGs.

5.8 Evaluating the qualitative research

Reliability and validity in qualitative research is made up of four criteria: credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985).

The following section discusses some established ways of evaluating the reliability and validity of qualitative research and how these were applied to the current study.

5.8.1 Credibility

Credibility refers to whether the researcher produces a feasible account of participants' responses (Bryman, 2008).

Triangulation was sought in the current study as a measurement to ensure credibility. Triangulation refers to combining different methods or different sources of information to obtain a rich picture of the issue under investigation (Silverman, 2010, Bryman, 2008). Using different methods in collecting data, such as focus groups and individual semi-structured interviews, may compensate for their individual limitations. Furthermore, using more than one source of information may allow verification of experiences against

one another (Shenton, 2004). In the current study, IMGs and patients' accounts were drawn together to develop the themes.

Additionally, in presenting the findings, the researcher sought fair representation of participants' responses by highlighting and discussing responses that countered the majority response.

5.8.2 Transferability

Transferability is the degree to which findings can be transferred to other settings. Qualitative researchers do not seek generalizability to other settings; rather, they seek to gain an in-depth understanding of events in peoples' everyday lives. Therefore, qualitative studies do not usually require large numbers of participants (Bryman, 2008). Whilst the aim of qualitative research may not be to produce reproducible findings, it might be expected that the findings could be generalizable in the sense of being relevant in other settings or, in this case, to other groups of IMGs or diabetes patients (Green and Britten, 1998).

The aim of this study was to provide in-depth analysis of the issues under investigation for this particular setting. The finding of the current study could be potentially useful to other countries such as the Arab Gulf Cooperation Countries, which include Kuwait, the United Arab Emirates, Qatar and Oman where IMGs have the same status and similar cultural structure is found.

5.8.3 Dependability

Dependability refers to the degree to which a study can be replicated to produce the same findings. Post-positivists acknowledge that the social world is constantly changing and a study itself might affect the world it is trying to document.

Using maximum diversity sampling in the current study helps in mediating these changes by including the behaviours, perspectives and needs of people from different age, gender and socioeconomic levels. Being transparent through all phases of the research and providing detailed information with regards to problem formulation, selection of potential participants, taking field notes, data analysis decisions, and so on, were sought (Bryman, 2008). Furthermore, complete records of all phases of the study were presented in this thesis. These included the basis on which this topic was conceived, details about selection of the participants, and data analysis decisions.

5.8.4 Confirmability

Confirmability means ensuring that personal values and theoretical inclinations are not allowed to influence the conduct of the research, nor the findings deriving from it (Bryman, 2008). This can be achieved by being reflexive about the researcher's role throughout the research process. It should be noted, however, that complete objectivity is impossible in qualitative research.

Guba and Lincoln (1994) described reflexivity as "progressive subjectivity" as this practice allows the researcher to make his or her socio-cultural position explicit to the readers. Thus, the reader will have the ability to judge whether the researcher's position interfered with the research process.

Researcher bias may be an important concern if the researcher enters the field with previous experience and pre-existing ideas (Silverman, 2010). This might put her at risk of attempting to focus on the points that feed a pre-existing idea. In this study, the researcher aimed to play a neutral role, as much as possible, throughout the data collection and analysis process. The researcher shares the same professional background

as the IMGs, as well as their work experience and familiarity with the requirements of successful patient-physician interaction. Furthermore, the researcher had experience of being used as an interpreter between Saudi patients and IMGs during her internship. In this sense, the ability of the researcher to present a combination of the emic and the etic perspectives (see section 5.3) helped in bringing personal and professional understanding to the research process, as well as descriptions of the experiences of IMGs and Saudi patients with diabetes. IMG participants may have perceived the researcher as a fellow professional who is concerned about developing the service, which may make them more candid in revealing their views and experiences. At the same time, however, the researcher is Saudi, and this fact may mean that they hold back from revealing negative views related to Saudi people or the Saudi culture, as in their minds, she might identify with the patients in this sense. The researcher was born and lived in SA for 26 years. Thus she might share the same culture with the patients studied, but not their experiences, as she is not a patient with a chronic health condition. Patients may see the researcher as a Saudi female who understands their perspectives and cares about their experiences with IMGs. Being a female who interacts with male participants without a male guardian may prevent some male patients in the conservative Saudi culture from being involved with the researcher in lengthy conversations. As the researcher shares the experiences of the IMGs and the culture of the patients, she might be in a strong position to understand the participants and then interpret the data. However, it also requires her to be alert regarding how the participants may view her, as well as requiring awareness of the fact that her own vantage point will inevitably influence both their interactions and the data produced. The research supervisors, who belong to a different contextual background, engaged regularly

in discussions on data analysis with the researcher. This added a deeper level of reflexivity, as they raised issues and asked questions that helped to explain hidden meanings, which had been overlooked by the researcher, who belongs to different culture from that of the supervisors.

5.9 Summary

Qualitative methodology was chosen to explore IMGs and patients experiences as cultural issues and deep understanding of the issues under investigation are better explored using this methodology.

A focus group discussion with IMGs and interviews with patients with T2DM from one hospital and interviews with IMGs and patients from eight different PHCCs in Riyadh, SA were conducted. Additionally, follow-up interviews with a number of the IMGs were conducted. Data were analyzed using a thematic approach proposed by Ritchie and Spencer (1994) and based on the principals of grounded theory. Reliability and validity of the data were discussed and established through triangulation, fair presentation, reflexivity and transparency. The following chapter will present the outcome of the data analysis.

Chapter 6

Findings of the study

6.0 Introduction

This chapter begins by presenting the descriptive data of the study participants. The findings from the thematic qualitative analysis are then presented. The data analysed revealed three different themes related to IMGs and patients' experiences in cross-cultural medical communication, which affect health care provision in SA. These themes are presented in three sections within this chapter:

1- Interaction and rapport-building in cross-cultural medical encounters

2- Providing culturally sensitive lifestyle advice

3- Practical strategies used by IMGs and patients to facilitate communication

6.1 Descriptive Data

6.1.1 IMG characteristics

All the contacted PHCCs agreed to participate in the study. Nineteen IMGs were recruited in the current study (Table 6.1). Eight IMGs were recruited from the hospital, of whom six underwent a focus group discussion. The other two IMGs were interviewed individually, as they had agreed to participate, but were not available at the time of the focus group.

Being in a focus group did not discourage some IMGs from sharing their negative experiences such as their inability to communicate with Saudi patients. The IMGs were keen to share their experiences with the researcher and with each other. The interaction between the focus group participants was apparent through them prompting each other's responses.

Table 6.1 IMGs' characteristics

IMG no.	Type of participation	Nationality	Age (years)/ gender	Mother tongue	Years of experience in SA/ PHCC	No. of T2DM patients seen/week	Follow-up interview
1	Focus group	Pakistan	46/M	Urdu	9/Hospital	60	-
2	Focus group	Pakistan	56/M	Urdu	4/Hospital	30-35	-
3	Focus group	Kashmir	54/M	Kashmiri	3Y6M/ Hospital	40	-
4	Focus group	Sudan	50/M	Arabic	20/Hospital	75	-
5	Focus group	Sudan	54/M	Arabic	20/Hospital	70-80	-
6	Focus group	Syria	38/M	Arabic	10/Hospital	70	-
7	Face to face	Sudan	32/F	Arabic	9/Hospital	80	-

IMG no.	Type of participation	Nationality	Age (years)/ gender	Mother tongue	Years of experience in SA/ PHCC	No. of T2DM patients seen/week	Follow-up interview
8	Face to face	Egypt	55/M	Arabic	16/Hospital	125	-
9	Face to face	Pakistan	46/M	Urdu	9y/East1	30	-
10	Telephone interview	India	40/M	Hindi	4y/North1	25	Yes
11	Face to face	Syrian	47/F	Arabic	6y/North2	30-35	Yes
12	Face to face	Sudan	38/F	Arabic	2y4m/East1	30	-
13	Telephone interview	Egypt	50/M	Arabic	8y/East2	25-30	-
14	Face to face	Pakistan	40/F	Urdu	4y/North3	25	-
15	Face to face	Egypt	57/F	Arabic	9y/South1	35	-
16	Face to face	Egypt	32/F	Arabic	4y/West1	25-30	Yes
17	Face to face	Jordan	59/M	Arabic	29y/South1	25	-
18	Face to face	Bangladesh	49/F	Bangla	3y/West2	30	Yes
19	Face to face	Pakistani	51/M	Urdu	20y/West2	35	Yes

Fifteen IMGs were approached and 11 agreed to be interviewed from the PHCCs, both males and females. Three female and a male Arabic speaking IMGs could not find the time and were not willing to be interviewed by phone. Nine interviews took place on the health care premises. Two telephone interviews were conducted based on physicians' preference, for which consent forms were signed in advance in the PHCCs. The reason given for preferring telephone interviews was due to the IMGs' busy schedule during working hours. IMG15 was the only participant who refused to be recorded. Reasons for preferring not to be recorded was attributed to fear of being identified, although the

anonymity of potential participants had been explained thoroughly. The participant's wish was followed and notes were taken during and immediately after the interview. No specifically sensitive issues, compared to the other interviews, were raised in this particular interview.

The IMGs were eager to share their experiences with local patients. It seemed that they took the interview as an opportunity to air complaints and sometimes it was difficult to move on with the related topics, as IMGs complained about administrative issues. Some IMGs also expressed their appreciation of the researcher's effort to deliver their voices and hoped that she could act upon their needs.

Five IMGs were included in the follow-up interviews as four did not respond, one IMG moved to another city, three were on vacation and one IMG was not willing to be included in a follow-up interview.

6.1.2 Patient characteristics

Sixteen Saudi patients with T2DM were recruited in the study (Table 6.2). Twelve of them were from the PHCCs and four from the hospital.

Table 6.2 Patients' characteristics

Patient	Age/gender	Education	Time since diagnosis	Treating physician	PHCC
Patients from PHCC					
P1	35/F	Higher education	3 years	-	North1
P2	57/M	Community college	5 years	IMG9	East1
P3	42/M	High school	3 years	IMG9	East1

Patient	Age/gender	Education	Time since diagnosis	Treating physician	PHCC
P4	62/F	Primary	12 years	IMG12	East1
P5	55/F	Secondary	6 years	-	East2
P6	50/F	Secondary	8 years	IMG16	West1
P7	39/F	Secondary	7 years	IMG 15	South1
P8	43/M	Community college	2 years	IMG17	South1
P9	60/M	Primary	6years	IMG19	West2
P10	56/M	Community college	9 years	IMG19	West2
P11	67/M	Illiterate	4 years	IMG10	North1
P12	65/M	Community college	6 years	IMG10	North1
Patients from KKUH					
P13	70/F	Illiterate	5 years	Hospital	---
P14	45/F	Secondary	10 years	Hospital	---
P15	65/F	Secondary	4 years	Hospital	---
P16	58/M	Illiterate	7 years	Hospital	---

Of the physicians who were asked to recruit "hard to reach" patients or "non-attenders" who may have poor control over their diabetes only one patient was recruited (P1) and 3 others were suggested to the researcher by the IMGs (P3, P10 and P11).

All patients were interviewed on the health care premises apart from one female patient (P1) who chose to be interviewed in a café.

6.2 Language as a barrier to communication

The language/dialect barrier to IMG-patient communication and interaction was identified as a distinct issue that cuts across all the themes identified from the data. It is well known from the literature, and apparent from the study's findings, that language/dialect is a common barrier to effective cross-cultural communication. This subject has already been extensively studied and researched and therefore it is not the intention of this study to present issues related to language in particular. However, it is important to provide some general context concerning language and dialect in SA before presenting the study's findings. This will help readers to understand the relevant language issues that influence cross-cultural medical communication in SA.

6.2.1 An overview of language in medical encounters in Saudi Arabia

Unfamiliarity with the Arabic language, per se, is not the only issue affecting the quality of communication and interaction between IMGs and their patients. IMGs' and patients' Arabic dialects and accents can also be a barrier to understanding.

As SA is a vast country, people from each region communicate in different dialects that might not be easily understood by IMGs. Riyadh, where the study was conducted, is the capital city, in which patients from all regions of SA can be found. In addition to the difficulties in understanding Arabic language and the spoken dialects, non-Arabic speaking IMGs, in SA, also have difficulties expressing themselves because of the language and/or accent barrier.

According to the IMGs in this study, reaching a level of mutual understanding with older patients requires more effort, as it is difficult for older patients to understand different accents compared to younger people. This can be attributed to the fact that older people are

less exposed to expatriate workers and media in general and hence less familiar with dialects and accents other than their own.

Furthermore, it appeared from the findings that the IMGs acknowledged the difficulty of communicating with patients regarding chronic diseases, in general, when they do not share the same language with their patients. This was because explaining a condition and exchanging information to reach a mutually agreed management plan, as well as discussing details such as lifestyle modifications, medication, and complications related to the disease, is uniquely important in case of chronic disease.

Difficulties with language, dialects and accents emerged in the findings as obstacles that may affect the quality of diabetes care provision by IMGs in SA. In this case, mutual understanding and hence basic medical communication, interaction and rapport building can be difficult to achieve. One of the IMGs from the focus group discussion, who has worked in SA for more than three years, reported:

> *"I am mentally retarded because I regard myself; because my language skills are absolutely none, I cannot converse. I have no fluency in Arabic. I'm very pathetic in this conversation with the patient.   Because clinical medicine means I have to connect to the patient. For that my language skills are absolutely horrible, they are atrocious. I shouldn't talk. For a clinician, it [language] must be absolutely fluent"*
> *[sic]*
>
> *(IMG3, Kashmiri) Focus group discussion*

This IMG was frustrated because he was not fluent in Arabic. He felt that he could not be adequately involved in patients' care because of his limited Arabic proficiency.

In general, language, dialects and accents were widely recognised as barriers to effective IMG-patient communication.

Furthermore, during the focus group discussion, an Arabic speaking IMG was unable to understand a non-Arabic speaker when he was trying to give an example in Arabic. This may reflect the situation between IMGs and patients where patients may not understand different accents.

Section 1

6.3 Interaction and rapport-building in cross-cultural medical encounters

Interaction and rapport-building emerged as a theme from the findings as challenges in cross-cultural medical settings for reasons related to verbal communication, as described in section 6.2, and as well as to cultural differences between IMGs and Saudi patients with T2DM. The lack of communication, in addition to cultural differences, between IMGs and patients, had led to lack of understanding each others' expectations.

This theme includes the following subthemes: rapport building and quality of care provision; different expectations between IMGs and patients; patient-physician power dynamic; prejudice in the medical interaction; and the influence of coping with cultural challenges on care provision.

6.3.1 Rapport-building and quality of care provision

Most of the IMGs in the study were aware of the importance of rapport-building to improve patients' compliance and quality of care provision. For example, one IMG explained:

"Every consultation is a failure if you don't develop rapport between a patient and the doctor. Consultation is mainly rapport building. Once the patient develops confidence in you, only then he'll follow your plan"

(IMG 18, Bangladeshi)

Despite the clear relationship between language, rapport-building, and quality of care that forms the basis of the ensuing patient-physician relationship, one IMG did not support a direct relationship between rapport-building and quality of care as he believed that language familiarity influences rapport-building but not quality of care. He explained:

"I don't think this [familiarity with the language] has to do with the quality of care delivered to the patient, but it has to do with the rapport, as we said"

(IMG10, Indian) Follow-up interview

The above IMG indicated he was not keen to build rapport with his Saudi patients with T2DM because he believed that with rapport, patients may feel more comfortable to complain about unrelated things. He noted:

"With rapport, they would complain a lot. When they know you, they would start complaining [...] They gather all their complaints and just throw them up on the table, even if it's not related to their visit" [sic]

(IMG10, Indian) Follow-up interview

This IMG's view contradicts the view that language discordance creates a barrier to effective patient-physician interaction by showing a different view of effective interaction, in which

120

the care is better if the physician sets the agenda, rather than the participatory approach, which considers patients' priorities and concerns.

The majority of the IMGs accepted that Saudi physicians could establish rapport with patients more easily for reasons related to language and culture. However, during the focus group, IMGs suggested that local patients might prefer them over Saudi physicians. The reasons for this perception were attributed to the highly selective process that they have been through before they have being selected to work in SA, which suggests to patients that they are highly qualified physicians. Additionally, although Saudi medical graduates can be more familiar with the local culture and mentality and with the social structure of the community, a small number of the IMGs stated during the interviews that they believed that they were preferred by patients over local physicians, as they are considered less judgmental and more likely to respect confidentiality. They think that patients do not like to be exposed and judged by Saudi physicians who, unlike IMGs, are more likely to socialize with local people and are perceived to share confidential information about patients. This belief was noted among a small number of non-Arabic as well as Arabic speaking IMGs. For instance, one IMG from Bangladesh noted:

> *"If they [patients] discuss their social problems with their own national, they think that they are exposed in front of others, but with the expatriate they know maybe the expatriate won't be interacting with the Saudis. So, this could be the issue of confidentiality […] the reason behind this might be because of the closed society here, because they are living in a closed society, they don't want to disclose their problems in front of others"* [sic]

> *(IMG16, Bangladeshi) Follow-up interview*

Overall, the majority of the IMGs believed in the importance of good communication and interaction to achieve high quality care. They also agreed that obstacles to building rapport and delivering high quality care could be overcome with time. As one IMG stated:

"These things [rapport-building] need skills that cannot be established in a short period of time" [Translated]

(IMG12, Sudanese)

6.3.1.1 Patients' information disclosure

Responses from the patients showed that not sharing the same cultural background and language with the IMGs can affect patients' willingness to disclose certain information about culture that is deeply rooted in the community and may directly affect their health. This is because patients may have preconceived ideas that IMGs are not familiar with these issues and hence will not understand their patients and be able to advise them properly, regardless of IMGs' actual familiarity with the culture. For example, patients tend to believe that Saudi physicians are better able to understand their patients when they discuss alternative medicine, because they share the same cultural beliefs, while IMGs may never have heard about it, as they may have never used it in their home countries. This idea perceived by a small number of the Saudi T2DM patients, made them retreat from disclosing information about their use of alternative medicine to IMGs. For instance, one patient, when asked about disclosing information to her IMG, stated:

"Saudi doctors would understand the use of alternative medicine but expatriate doctors wouldn't; because they do not use it. This is a whole science that we

have been raised with. It is not something you can learn in a year or two. We

make recipes of herbs for certain diseases and they work!" [Translated]

(Patient 15)

Patients' reluctance to disclose information that is related to their health can hinder the exchange of information that might be considered important in the delivery of appropriate diabetes care.

6.3.2 Different expectations between IMGs and patients

One of the challenges to building rapport in cross-cultural medical encounters that emerged from the data was the different interaction and relationship-building expectations that several IMGs reported.

It appeared that some IMGs had to change their rapport-building style to suit Saudi patients' expectations. For example, an IMG from Bangladesh initially started applying her usual way of dealing with Bangladeshi patients, with her Saudi patients; however, she realised that adapting new strategies to deal appropriately with Saudi patients is important to make patients feel more comfortable with her. She stated that:

"What the patient wants from me is different here than in Bangladesh [...]

initially I was applying the techniques that I used to apply in Bangladesh, but

then with the passage of time I came to know that I have to change a little from

my side because what the patient expects from the doctor is different here than

in Bangladesh" [sic]

(IMG18, Bangladeshi)

The findings showed that the relationship style preferred by Saudi patients, according to the IMGs, is a formal relationship, which can make it difficult for IMGs to probe aspects

of patients' lives that can help them to set a practical management plan for their health condition, and may preclude non-health related conversations, which can be a strategy to build rapport. For instance, the same IMG observed this:

"They [patients] don't want me to probe. They want to be just to the point. "This is the problem and you just give us the solution!" [...] as a family physician we need to explore the patient and know what the exact hidden agenda behind the symptoms is"[sic]

(IMG18, Bangladeshi)

According to another IMG from Egypt:

"Sometimes when I try to joke about something with Egyptian patients they laugh and take it easy but Saudi patients think the relationship should be more formal. They may find it inappropriate if the doctor joked about anything" [Translated]

(IMG16, Egyptian)

It appears from the findings that the IMGs are aware of the cultural differences and have adopted new approaches to meet Saudi patients' expectations who, according to them, tend to appreciate a formal relationship with their doctors. Nonetheless, most of the IMGs in the study did not like this kind of relationship with their patients.

While the IMGs related Saudi patients' preference of a formal relationship to their culture, the Saudi patients themselves stated that they avoid having non-health related conversations with IMGs, specifically, because they do not feel that their IMG physicians understand them easily. They described their relationships with Saudi physicians as less formal than those with IMGs because of the ease of communication and mutual

understanding. For example, one patient from the hospital, who had the chance to see Saudi and IMG physicians, explained that Saudi physicians understand her without effort, which makes it easier for her to express herself and her concerns, enabling the Saudi physician to provide appropriate care. She noted:

"It is most of the times formal [the relationship with IMGs] [...] I talk more with Saudi doctors because I know they understand me immediately and they are open to listen" [Translated]

(Patient 15)

Therefore, the findings showed that there are conflicting expectations between patients and their IMGs. While IMGs thought that patients wanted a formal relationship with their physicians, patients assumed that they have to deal with their IMGs formally as mutual understanding may not be easily accomplished.

6.3.2.1 Shared decision making

Shared decision making (SDM) is one of the key components of patient-centred care that strongly requires developing a partnership with the patient.

Regardless of its application in practice, it appeared from the findings that SDM could be influenced by the relationship between the IMGs and their patients.

This could be attributed to the power dynamic and the presence of prejudice in the medical relationship, which will be discussed later in this section (see 6.3.3 and 6.3.4). It appeared that when some patients were dominant over their physicians, there was no place for exchanging information, as the patient could impose his or her wishes over the physicians' recommendations. For example, according to one IMG:

"Patients are either "passive" or "want to be the doctor". Passive patients receive information from, but not share information with, the doctor. These patients may or may not follow your advice. The other type of patients wants to choose what they prefer from their observations outside the clinic, of their family and friends, without my help" [Translated]

(IMG12, Sudanese)

Despite some patients expressing their preference for SDM during medical interviews, most of the IMGs avoided presenting management plans for their patients to choose from, to avoid losing their patients' trust. These IMGs assumed that patients might view their physicians as less professional and categorise them as less trustworthy if they shared treatment options with them. A small number of the IMGs tried to ascertain patients' opinions regarding the treatment plan without letting them know their intention in an attempt to preserve the trust between them. One IMG stated:

"You cannot do this shared decision making directly with the patients here. I give them what I see as the best for them, then check with them if they can follow it or not. In this way I can involve them in making the decision without affecting their view of me" [Translated]

(IMG11, Syrian)

One of the IMGs from Pakistan believed that as rapport is difficult to build with local patients, SDM has no place during the medical interview. Additionally, she believed that patients are not as concerned about SDM as they are about getting their medication. She explained:

126

"That [SDM] I do in Pakistan. My patients are my friends. Here, patients will never be your friends, they don't want to be. They want their medications, I give medications…" [sic]

<div align="right">*(IMG14, Pakistani)*</div>

On the other hand a small number of patients preferred to discuss different options with their doctors. A 65 years old educated patient explained:

"Yes, I would love to discuss treatment options with the doctor because you need to choose what better suits your own lifestyle" [Translated]

<div align="right">*(Patient 12)*</div>

The data showed conflicting expectations between IMGs and patients. While IMGs' believe that they should not openly discuss options regarding management plans with their patients, as this could negatively affect trust, some patients expressed their preference of the SDM approach.

6.3.3 Patient-physician power dynamic

The power dynamic in the IMG-patient relationship can be a source of problematic communication and interaction. It was noted from the IMGs' responses that in SA, they do not feel that they are "ethnically" equal; nor do they feel that they have an equal say with the patients during medical consultations. A Sudanese physician reported:

"Patients may consider themselves equal to Saudi doctors but not to expatriate doctors" [Translated]

<div align="right">*(IMG12, Sudanese)*</div>

A power differential is always likely between physicians and patients due to education or expert knowledge, and a completely equal relationship is difficult to achieve. Although ideally, the power during medical consultation should be shared between the physician and the patient, if the power was strongly biased then it is usually given to the physician in what is referred to as "vertical" relationship. Nevertheless, in SA the picture is different, in the sense that Saudi patients have 'the upper hand' during the consultation with IMGs. One patient agreed with the IMGs with regards to patients' control over the medical consultation. This patient allowed herself to speak on behalf of other T2DM patients when she said:

"Patients feel that they have the right to control the doctor!" [Translated]

(Patient 12)

Furthermore, it is interesting to note that one of the IMGs believed that doctors' superiority over their patients is a recognized fact, commenting that:

"In all countries where there is doctor-patient relationship, the doctor is superior to the patient"

(IMG10, Indian)

However, when he was asked about the applicability of his statement in SA, he denied the superiority of physicians.

IMGs from the focus group discussion thought that the local patients liked to be seen by IMGs because they could be dominant over their doctors, as one IMG explained:

128

"When the patients see the expatriate doctor, they impose all of their things on

the doctor, they think that we are dominant on the doctor [...] they really

become dominant on the doctor" [sic]

<div align="right">

(IMG1, Pakistani) Focus group

</div>

In the case of patients' dominance during medical interviews, IMGs may not have a suitable environment to apply their knowledge and interaction skills. This attitude on the part of patients has been mainly attributed to the presence of prejudice in the patient-IMG medical interaction, which is discussed in the section below (see 6.3.4)

6.3.4 Prejudice in medical interactions

This subtheme was based on the IMGs' perception, as rather than describing themselves as being prejudiced, patients were accused of prejudice by most of the IMGs.

Most IMGs, including Egyptian IMGs having experienced this first-hand in some cases, attributed the power dynamic between IMGs and patients in SA to the presence of prejudice in their interaction. An IMG sounded emotional when he stated:

"I feel as if I am a second-class citizen, not an honoured doctor who came

from Egypt" [Translated]

<div align="right">

(IMG13, Egyptian)

</div>

This perception was explained by another IMG who felt insulted by some of her local patients:

"When I came here, they [Saudis] used initially to make fun of me that this is

the first time you sit in the airplane. This is the first time you travelled

somewhere abroad. They have this perception in their mind that people who

are coming here they are from very remote areas. They are very poor people"

[sic]

<div align="right">

(IMG18, Bangladeshi)

</div>

The majority of the IMGs, regardless of their mother tongue, had experienced acts of discrimination from their patients, at least once. For example, an IMG heard hurtful words from one of her Saudi patients who wanted to shift from insulin to oral hypoglycaemic agents after seven months of using insulin, purely on the basis that her friends used oral medication. This IMG explained with anger:

"I told her joking, "seven months and you are thinking of shifting to insulin now?" she replied furiously "Who are you to judge me or refuse to do what I ask you to do? God knows what might happen to you if we did not bring you to our country!" [Translated]

<div align="right">

(IMG12, Sudanese)

</div>

IMGs used words such as "angry" and "sensitive" to describe their feelings towards prejudice. Their negative feelings were obvious from their voices and expressions. However, all of them confirmed that their experiences and feelings did not negatively affect the quality of care they provided their patients with. In fact, the same IMG who acknowledged the importance of rapport-building in developing trust between physicians and patients to improve quality of care found excuses for patients' prejudicial attitudes. This IMG accepted this attitude by explaining that when someone is in their own country, they have the power and hence they are expected to have more control in relation to foreign people. She asserted:

"If they [local patients] behave like this, it's their own country. When you are in your country, you are more powerful. You are more confident. So, as this with them, we are foreigners here, so we have to behave like foreigners [...] this is their own national country. They are free to behave in their own country"

(IMG18, Bangladeshi)

Additionally, some of the IMGs thought that such behaviour was expected from a tribal community, which they believed is the case in SA:

"This is the structure of the people here. It is a tribal community. This phenomenon can be seen even among Saudis themselves, so you can expect how it can be with others" [Translated]

(IMG11, Syrian)

Although this idea may sound like prejudice on the part of the IMGs (see section 6.4.3.1), it reflects their awareness of the community structure in SA, which can be described as tribal.

6.3.4.1 Racial stereotyping

Some IMGs were able to present reasons for the presence of this phenomenon. The background behind prejudice in cross-cultural medical interaction in SA was attributed mainly to relating IMGs to various strata. According to the IMGs, patients are used to giving orders to people from certain communities in SA. According to one IMG:

"Nationalities like Indian and Pakistani can be linked to domestic labour and

patients are used to giving orders to these people and they think it is the same

with the doctor" [Translated]

(IMG11, Syrian)

Participants from the focus group discussion did not take offence from the fact that they are looked at as "servants". They explained that this view made patients believe that taking good care of them is one of the IMGs' duties and for that they might prefer to be seen by IMGs. One IMG noted:

"They [patients] can explain each and every thing in detail to non-Saudis, they

think that these are our servants, they have to take care effectively and they

cannot say to Saudi doctors – these are our servants" [sic]

(IMG1, Pakistani) Focus group

As was noted above, although the IMGs' views in both the focus group discussion and individual interviews were the same, they were presented differently in each type of interview. While IMGs from the focus group discussion presented patients' perception of them as, more or less, positive in terms of their image as professional doctors, their colleagues from individual interviews were more overtly concerned by local patients' perceptions of them.

A small number of the IMGs expressed their preference for the formal relationship that they thought Saudi patients favour as a defence mechanism for possible discriminatory acts from their local patients. For instance, one IMG explained:

"Some of them do not respect me just because I am from Pakistan and they have a maid at home from Pakistan too and link this together. Treat me like their maid. I am very formal with them, this works for me!"

(IMG14, Pakistani)

It appeared from the data that a formal relationship with their patients can guarantee avoiding more non-health related talks that may lead patients to express their negative feelings if they have the opportunity to do so.

Patients, according to a small number of the IMGs, have a concept that they apply to all expatriate workers in SA. They believe that patients think that they own a person if they, or their country, pay him or her. An IMG explained:

"There are some who think that as long as their country pays me then I belong to them and I have to obey their requests without negotiation" [Translated]

(IMG12, Sudanese)

This was illustrated by IMGs' examples of prejudice from their patients. Another IMG from Sudan noted:

"I remember a patient came to me wanting a medication that she thought is the best for her, as her husband is taking that medication. She told me "why don't you just give me the medication? It's from my country's wealth". This made me angry" [Translated]

(IMG7, Sudanese)

One more reason was added by an IMG from Pakistan who expressed the view that Saudi patients act prejudicially because they do not like to see expatriates holding good jobs in SA while Saudi people struggle to find jobs.

In general, the existence of prejudice between physicians and patients can be an obstacle to appropriate interaction and rapport-building and hence to good quality medical care. As noted in 3.3.1, not accepting IMGs can be seen anywhere in the world, so it is to be expected in SA as well. However, patients' expression of non-acceptance and IMGs' reaction to these expressions can be different from one setting to another.

6.3.4.2 Positive stereotyping

The findings showed that Egyptian IMGs were more highly rated, by themselves and their patients, than other IMGs with regards to their communication skills and professionalism. Most of the Egyptian IMGs believed that they were more effective and popular than other IMGs because of their sociability, good listening abilities and attention to the psychosocial aspects of patients' care. For example, one Egyptian IMG noted:

> *"Egyptians' characters attract patients. They always know how to interact with*
>
> *patients. I am sure if you ask patients about their Egyptian physicians you*
>
> *would find that they have a strong bond with them. They care about diabetes*
>
> *patients from all aspects; they listen and care about patients' psychology"*
>
> *[Translated]*
>
> *(IMG16, Egyptian)*

Two of the patients also confirmed these positive characteristics when describing Egyptian physicians and even expressed a preference for them over Saudi physicians who share the same cultural beliefs. According to one patient:

"Saudis do take something from the desert; they are tough, unlike some Egyptian doctors who smile and try to explain and accept the patient as he is with their leniency" [Translated]

(Patient12)

It is worth noting that while this patient's responses showed respect and trust to Egyptian IMGs, his actions in the PHCC showed a prejudiced side of him as he was calling for doctors to prioritise seeing patients based on their nationalities; where Saudi patients should be seen before international patients.

According to one IMG, this preference for Egyptian physicians stemmed from the history of Egyptians in SA:

"We are known to have the best physicians in the Arab world. Pharaohs started medicine in Egypt a long time ago. We started this revolution. Egyptians used to come to Saudi and other Arab Gulf countries to teach people how to read and write. Patients know that! It is well known" [Translated]

(IMG16, Egyptian)

Two of the patients interviewed in this study assumed that local patients trust IMGs who come from the Western world, as they believed that they have received the best education doctors could get as they graduated from developed countries. A patient noted:

"Trusting IMGs depends on the nationality of the physician. If the physician were European or North American patients would trust him because it is well known that physicians who graduated from these places have received the best

education. On the other hand patients would not trust South Asian physicians"

[Translated]

(Patient 1)

Although both Western and non-Western IMGs do not share the same language and culture as local patients, this was not raised as an issue in regards to communicating with Western IMGs. It seemed that the quality of education of IMGs who graduated from the developed countries would compensate for the communication challenges.

6.3.4.3 Handling prejudice in the medical encounter

Most of the IMGs did not report prejudice from their patients to higher authorities, either because, according to them, they habituate themselves to it or out of fear of losing their jobs. It should be noted that patients are not directly capable of removing IMGs from their jobs, although, if a patient files a complaint about an IMG, their annual evaluation would be affected, which may make it possible to lose their job indirectly. Additionally, the IMGs said they avoided disclosing prejudice from patients to managers and supervisors of the PHCCs for the same reason. For instance, one IMG from Egypt noted:

"They evaluate us. If the expatriate doctor did not do well or the administration received a lot of complaints about her, the MOH may let her go. The manager of the centre and the supervisor can send her back to her country" [Translated]

(IMG16, Egyptian)

Other reasons for not handling prejudice, according to the IMGs, could be attributed to the physicians' personality, language proficiency and avoidance of attention for the sake of maintaining their jobs. An IMG explained:

136

"Some of the expatriate doctors cannot do that because they have weak personality, do not speak Arabic or just do not want to direct the eyes on themselves because if they do, their evaluation can be affected which means they are at risk of losing their jobs" [Translated]

(IMG11, Syrian) Follow-up interview

Moreover, one IMG did not feel comfortable complaining about Saudi patients to her Saudi supervisor because she felt that Saudi people would side with each other. She stated:

"Employees in the administration here are Saudis. Who can I go to!?" [Translated]

(IMG16, Egyptian)

Nevertheless, the IMG was just expressing her fears, as no one reported being unfairly judged by supervisors at any of the PHCCs. In a follow up interview, the same IMG reported:

"Even when patients complain to them about me, they [the supervisors] come back to me and ask me about details and most of the times they are on my side" [Translated]

(IMG16, Egyptian) Follow-up interview

One of the IMGs tried to report patients because of their prejudicial comments but failed to do so for reasons related to language, which appeared to be a barrier to reporting prejudice. A non-Arabic speaking IMG from Pakistan explained that she could not complain to the supervisor at the PHCC she works at because she does not speak English and her own Arabic language was limited. She reported:

"The supervisor doesn't speak English! I was exposed to a patient like this

from the second week, I wanted to tell the supervisor but there was no way, she

doesn't speak English" [sic]

(IMG14, Pakistani)

Another IMG believed that supervisors cannot help them to handle prejudice as she

cannot see how supervisors can assist her in these situations. She stated:

"What can supervisors do?...Nothing!" [Translated]

(IMG11, Syrian) Follow-up interview

It appears from this response that IMGs may not actually know where to go or who to

speak to in case they needed assistance in this regard.

Most of the IMGs reported that they try to avoid generating prejudice in the first place.

According to them, this may be achieved by learning Arabic, and by being confident and

formal with the patients. For example, an Arabic-speaking IMG stated:

"They should avoid being exposed to discriminatory acts in the first place by

showing a strong personality, good information and confidence in general.

This includes speaking or learning Arabic" [Translated]

(IMG11, Syrian) Follow-up interview

In case of experiencing prejudice, only one IMG expressed her preference for filing

complaints against patients rather than speaking directly to them. Her philosophy is to

ensure that she complains before her patients' do, to avoid an accumulation of patients'

complaints against her. She explained:

"Who said that she [the patient] would not file a complaint against me? I have

to be the first to avoid accumulating complaints against me" [Translated]

(IMG16, Egyptian) Follow-up interview

The above quote reflects an unhealthy relation between IMGs and patients that stemmed from IMGs insecurity about their job.

On the other hand, a small number of the IMGs preferred to deal personally with prejudice from patients, although using different strategies. Most IMGs refrain from reacting until this is untenable. An IMG said:

"If he [the patient] was really exaggerating, I would stop him. Otherwise, he

would leave my office in a few minutes. Why the hassle?" [sic]

(IMG10, Indian) Follow-up interview

Some other actions IMGs took in these situations varied between asking their patients to leave the clinic, or deflecting patients' anger as an attempt to set a good example by not reacting in the same way as them. For example, the same IMG who approved local patients' superiority was keen to positively present all other IMGs. She believed that if patients were confronted about their attitude, their action may persist and they may label all IMGs the same and treat them negatively. She noted:

"It's very easy to speak to them [patients] directly, tell them "please, this is not

the way to behave with us". What will happen? The patient's attitude will

persist. Whether she goes to some other doctor, some other expatriate, she'd

behave the same way. Because she had a bad experience with someone, but

139

with the passage of time, if we try to improve, maybe she'll change her

attitude"

(IMG18, Bangladeshi) Follow-up interview

IMGs not being able to share their concerns with higher authorities may lead to more difficulties in handling the situation of prejudice in medical encounters, and this can directly affect the quality of health care provision. Furthermore, it may complicate the mission of creating a good working environment for IMGs.

Finally, regardless of the cause, prejudice is considered inappropriate and can eventually negatively affect the IMG-patient relationship and hence the quality of care provision.

6.3.5 The influence of coping with cultural challenges on care provision

This subtheme emerged as a barrier to effective IMG–patient interaction that might eventually affect the quality of care provision in general, and of diabetes care provision in particular.

It appeared from the findings that IMGs and patients not being able to understand each other might lead to frustration of both. This in turn, can negatively affect the quality of care provision. For example, despite most of the patients expressing their desire to receive detailed information regarding their condition and medication, one patient shared his experience with a Pakistani IMG who could not satisfy him with the information he needed and finally gave up on explaining and asked the patient to take the pills and leave without considering his request. He reported that his Pakistani physician said:

"You don't speak English and I don't speak Arabic, just take these pills! One in

the morning and one at night" [Translated]

(Patient 11)

Furthermore, IMGs might not be able to satisfy patients by reassuring them about their health condition or providing them with answers to their questions, simply because of the language barrier. As one patient, who also sees Saudi physicians in a private hospital, explained:

> *"Now my doctor prescribes a medication and talks to me about it and how it works in my body. But with the Indian doctor! She would never be able to explain that. We cannot make a dialogue. Sometimes I am worried about something and I have to discuss it with the doctor and she has to understand me, direct me and give me solutions!" [Translated]*

> *(Patient 7)*

In general, IMGs may end up giving in to the difficulties they face when interacting with their patients and send them home without ensuring they are delivering the proper care required. This will eventually impact on rapport-building, compliance, diabetes outcomes and quality of care in general.

6.3.6 Summary

In summary, the findings within this theme showed that the IMGs and patients had different expectations of each other, which was a consequence of the cultural differences and lack of effective communication between both groups. Additionally, the existence of prejudice towards IMGs could strongly influence the effectiveness of medical care provision. Furthermore, the absence of an appropriate support system made IMGs struggle to find the best way to control prejudice and be able to focus on patient care.

Section 2

6.4 Providing culturally sensitive lifestyle advice

As mentioned earlier in 1.2, most Saudi people follow cultural customs and religious beliefs that inform their lifestyle, including diet and exercise. IMGs are expected to be aware of these customs and beliefs in order to be able to provide their local patients with appropriate advice and help them to better control their T2DM, in particular, or any chronic health condition in general.

IMGs, as general practitioners, are expected not only to be familiar with local customs and habits, but also to be able to provide culturally sensitive advice that is acceptable and achievable by local patients.

Findings within this overarching theme included three main subthemes: awareness of the local habits and customs, patients' attitude to IMGs' advice, and IMGs' approaches to advising patients. These are discussed in detail below.

6.4.1 Awareness of the local habits and customs

Analysis of the data revealed IMGs' awareness of three main lifestyle aspects, which included local diet and eating habits; physical exercise and; traditional medicine.

6.4.1.1 Local diet and eating habits

The IMGs showed familiarity with the foods in SA and were aware that "Kabsa" and dates are commonly consumed.

Some of the IMGs showed detailed knowledge about food consumption and gave suitable alternatives to the standard food, which illustrated a keenness to provide the optimum care and the best advice. IMG 15 from Egypt showed familiarity with types of dates produced in SA, acquired through internet searches, and explained that a subtype of dates called "Ajwa" is the one that is lower in sugar and hence better for T2DM patients to consume compared to all other subtypes.

Additionally, the IMGs were aware of the places where healthy food could be found in the city. For example, a patient participant talked about her experience with her Sudanese doctor, who not only advised her about the right type of rice to cook, but also was able to tell the patient where to find this type of rice. She explained:

> "I have changed from cooking Basmati rice to brown rice and whole-wheat spaghetti. She [her IMG] is the one who told me that I could find this kind of food in the "X" grocery store. You know you can't find some kinds of imported food everywhere!" [Translated]
>
> (Patient4)

Providing appropriate dietary advice was not restricted to IMG's knowledge about local food, however, familiarity with traditional food customs and social etiquette is also

important in enabling them to provide T2DM patients with the appropriate guidance. For example, IMGs not familiar with the etiquette concerning socialising around food, including the pressure to accept food offered by one's host, will be unable to deliver practical advice and strategies to deal with this social pressure and help their patients to overcome this obstacle. Patient respondents complained that their IMGs are not aware of issues around social pressure, and hence cannot assist them in this regard by guiding them in terms of the right way to reject food. One patient noted:

> *"Each country has its own food practice [...] You cannot refuse food offered by a friend! And if you tell them you are diabetic and cannot eat this, they say "just take one, it would not harm you!" you take one each time and here we go! Unless they [IMGs] live here for a long time and integrate with Saudi people to understand that, they would not be able to help properly"* *[Translated]*

> *(Patient8)*

This patient assumed that the only way IMGs can help their patients in this regard is by being exposed to local customs from local people, which can happen when IMGs are well integrated with the Saudi population.

However, follow-up interviews showed that most IMGs are in fact aware of the local social etiquette and are able to advise patients with T2DM by providing them with ways to deal with their health condition in social gatherings.

Furthermore, according to one IMG:

"Maybe the expatriate doctor is familiar with the customs and habits but cannot link her information with providing advice to patients, it is just not in her mind because she does not live that culture, she just knows it" [Translated]

(IMG16, Egyptian) Follow-up interview

According to the IMGs, it is important for patients with T2DM not to withdraw from the community just because they are diabetic. They asked patients not to reject food presented to them, but suggested that they should be selective with their choices. For example, one IMG from Pakistan noted:

"Don't reject them totally you can make healthy choices. Because suppose there is a dinner [...] Take a piece of ... for the diabetic patients, a piece of meat with bread, and a piece of fruit, and instead of tea or green tea with sugar you can take coffee something like this. You can make healthy choices" [sic]

(IMG19, Pakistani) Follow-up interview

Another approach proposed by IMGs to deal with patients in this regard was asking patients to inform their hosts about their health condition and to help them to be able to manage it. One IMG described:

"I ask them to tell their friends that they cannot eat certain food as they are diabetic and they are concerned about their own health. I also tell them to tell their friends "If you love me and want to help me to control my diabetes, do not insist that I take sweet food!"" [Translated]

(IMG11, Syrian) Follow-up interview

Nonetheless, an IMG from Egypt looked at the situation from another aspect. She believed that some patients might perceive their health condition as a stigma and

therefore prefer not to share this information with the host, or any other people. As a consequence, they compliment the host at the cost of their own health. In this case, she focuses on handling the issue of perceiving ones' health condition as a social stigma in order to be able to give the appropriate advice, stating:

"What I understood is that part of rejecting food is being worried that the host may take it personally [...] and the other part is social stigma as some ladies do not like to disclose to others that they suffer from diabetes or hypertension. We stress more on social stigma, so we tell them that diabetes and hypertension are very common and easy to control, there is nothing to be embarrassed about" [Translated]

(IMG16, Egyptian) Follow-up interview

Although IMGs have the knowledge that enables them to provide culturally sensitive advice, they sometimes lack the 'tools' to make this possible. As Saudis are very attached to their traditional food, it can sometimes be difficult for IMGs to provide alternatives to Saudi T2DM patients with regards to diet. One of the IMGs interviewed was unable to guide his patients to certain types of food that were healthier for them because of the limited variety of food they consumed. The IMG believed that even if he could advise patients to control the quantity of their food, controlling quality, which is equally important, could not be achieved because of the limited nature of the local diet in terms of variety. After 29 years of experience working in SA, including remote Bedouin areas, the IMG stated:

"...some patients, although they wanted to follow doctors' instructions, they didn't know what else to eat or even how to prepare anything else apart from

147

rice and meat. They try to control their food portions but the quality! It is

difficult" [Translated]

<p style="text-align:right">*(IMG17, Jordanian)*</p>

This quote indicates that some doctors' advice may not be considered by patients as practical, because IMGs do not know about or do not have alternatives to patients' daily food, or because their advice may not be presented with enough detail to understand and follow. On the other hand, some IMGs suggested practical strategies to facilitate patients to follow their advice, and these are discussed in section 6.5.

Although responses showed that the IMGs are aware of the local diet, it appeared that the idea that IMGs are not able to provide culturally sensitive advice is common among Saudi patients with T2DM. Some patients believed that IMGs are not familiar with the local diet and this allowed them to suggest types of food that Saudi patients are not familiar with. For instance, a young patient participant noted:

> *"The doctor might give the patient dietary instructions and suggest things that*
>
> *do not exist in the diet of the patients' culture. A doctor once told my aunt to eat*
>
> *broccoli! Broccoli is not a food that is produced in Saudi. A lot of elderly*
>
> *people do not know what broccoli is!" [Translated]*

<p style="text-align:right">*(Patient1)*</p>

While it was clear that most IMGs were familiar with the local diet, some of them may lack the skills to put their knowledge into practice during the actual medical interview.

Generally, it can be understood from the different IMGs and patients' perspectives that, despite most IMGs having familiarity with the local diet and eating habits, patients do not

necessarily trust their ability to give advice. Furthermore, it appeared that some IMGs were less able to provide culturally appropriate advice than their colleagues.

6.4.1.2 Physical exercise

The majority of the IMGs were familiar with the general nature of Saudi peoples' physical activity and they acknowledged that the society's specifications make it difficult for Saudi patients to exercise.

For example, one IMG from Syria was aware of the fact that it is socially unacceptable for older women in SA to visit the gymnasium as she explained:

"If the doctor thinks with her mentality, culture and habits, she would never understand that it is socially unacceptable in SA for a woman over 40 years of age to visit the gymnasium" [Translated]

(IMG11, Syrian)

A large number of the IMGs had considered culturally acceptable ways to exercise, and used this information to provide their patients with practical advice. They were familiar with the best places in the city to walk as a form of exercise and used this information to encourage their patients to walk. For instance, an IMG reported:

"I tell them to go into a place that they are equipped. They have water spring coolers and other people are walking there; it's nice" [sic]

(IMG9, Pakistani)

Furthermore, the IMGs were familiar with the most common housing structure in SA, which is a large house surrounded by an enclosed yard, and they used that knowledge to aid them in providing culturally sensitive exercise advice. For example one IMG stated:

"I ask old ladies to walk around their houses if they have a yard surrounding

the house or just walk inside the house" [Translated]

<div align="right">

(IMG12, Sudanese)

</div>

This type of advice shows IMGs' awareness of the cultural aspects of patients' lives. It avoids exposing the patients to societal taboos such as females exercising.

Other IMGs ask their patients to walk to a mosque that is further away from home, as they know that most Saudi males prefer to perform their prayers in mosques, which are scattered in abundance in each neighbourhood, making it easy to find many mosques within walking distance.

Despite IMGs' awareness of, and the ability of most of them to provide, culturally appropriate exercise advice, it appears from the perspective of some of the T2DM patients that they are not getting the appropriate exercise advice from their physicians. For example, the patients mentioned that they receive 'general' advice about walking and visiting the gymnasium. One patient aged 62 years mentioned:

"She [her IMG] told me to walk every other day and go to the gym but you

know…!" [Translated]

<div align="right">

(Patient4)

</div>

In general, it should be noted that most IMGs were able to provide culturally sensitive exercise advice, but patients do not necessarily acknowledge their knowledge and familiarity with the social structure and specifications.

6.4.1.3 Traditional medicine

Most of the patient participants used natural remedies to help manage their diabetes. They mentioned using "fenugreek", "garlic", "honey", "nigella" "marjoram" and many other natural products and herbs to help them to control their diabetes.

The majority of the IMGs were aware of their diabetes patients' use of traditional and herbal medicine. Some of them were also aware that this kind of medicine is mentioned in Quraan and Sunnah (Prophet Mohammad's teaching) and the Saudi culture supports its use. An IMG noted:

> *"The uses of herbal remedies were mentioned in Quraan and Sunnah. Honey, cumin, and nigella were all mentioned. Their use is embedded in the Islamic religion and supported by the culture as well"* [Translated]
>
> *(IMG17, Jordanian)*

On the other hand, a small number of IMGs were not sure about advising patients about using herbal medicine therefore, their decision about whether to advise patients to use, how to use or not to use traditional medicine, varied.

For example, IMG 15 from Egypt thought that using herbal remedies was acceptable. In fact she witnessed number of T2DM patients who had improved blood glucose readings after they used ginger and sage.

Other IMGs advised patients to use it, but, with some reservations. An IMG from Pakistan suggested that for natural remedies to work properly without harming patients they should be consumed fresh or "natural" and in certain amounts. He gave an example of using honey:

"…We should use it [honey] very carefully and very scientifically. If a person

is using 20 ml of honey for diabetes we should explain this is okay. First of all

you have to check if it is natural…" [sic]

(IMG19, Pakistani)

This IMG specified that using natural honey that is supported by scientific research might

not be harmful for diabetes patients.

Some of the other IMGs were not sure about the effectiveness of natural remedies to

control T2DM because, according to them, there is no evidence about their use; therefore,

they were not comfortable about bringing this topic up during their consultations with

diabetes patients. According to one IMG:

"They think natural remedies are the cure for diabetes. They might even replace

the prescribed medication with ginger or honey! We do not have these beliefs in

Egypt. I do not discuss herbal use with the patients because I am not sure about

its effectiveness […] I do not think there is evidence about that" [Translated]

(IMG16, Egyptian)

Regardless of their beliefs in traditional medicine, some of the IMGs tried to avoid

advising their patients to stop using them because they thought they might lose these

patients' trust, as they believed that this kind of medicine is deeply rooted in their culture.

An IMG explained:

"If you straightaway say, this thing [alternative medicine] is wrong, meaning

you say your father was wrong. Your mother was wrong. So we cannot say

straightaway like this" [sic]

(IMG18, Bangladeshi)

Generally, regardless of the effectiveness of alternative medicine, and despite all interviewed IMGs being Muslims and expected to be familiar with medicine approved of by the Prophet Mohammad, it appears that some IMGs were not sure about providing advice regarding herbal medicine, while others avoided talking to their patients about it because they think it has not been adequately researched.

6.4.2 Patients' attitude to IMGs' advice

It appeared from 6.4.1 that patients acknowledge neither the IMGs' knowledge nor the effort involved in advising them.

Not acknowledging IMGs' knowledge can be attributed to the difficulties patients face regarding acting upon some advice, such as physical exercise advice compared to dietary advice. For example, one patient noted:

> *"…It is always easier to control diet, I cannot commit to exercise"*
>
> *[Translated]*
>
> *(Patient4)*

This kind of attitude from patients could make them less likely to listen to IMGs' advice regarding physical exercise, and hence less likely to remember it.

Most IMGs attributed patients' attitudes of acknowledging neither the IMGs' knowledge nor the effort involved in advising them, to patients' preconceived stereotypical ideas about IMGs, including the notion that these physicians cannot provide culturally sensitive and practical advice, as they do not share the same culture as their patients. For this reason, no matter how much effort IMGs made to improve their advising strategy, patients may not see it or acknowledge it. One of the IMGs explained:

153

"As the patient enters the room, it's at the back of her mind that, "The person I am visiting is not Saudi. He doesn't belong to my culture; he or she doesn't belong to the environment where I'm living." So, if we try to maybe educate them, we try to convince them to change their lifestyle or do whatever is good for them, it's difficult for them to accept. Maybe, they might be thinking that he doesn't know what their actual culture is, so the education that we are giving is not applicable, but if the same education is being delivered by their own Saudi nationals, they have in their mind that, "She is coming from the same background, she knows our background. If we apply her teachings, it will be more convenient for us to apply."

(IMG18, Bangladeshi) Follow-up interview

It could be expected that this idea about Saudi patients may also drive IMGs to adopt inflexible approaches to advising patients (see section 6.4.3).

Additionally, language issues contributed to patients' attitudes towards IMGs' advice. IMGs explained that it could be difficult for patients to keep the information provided by their doctors, especially non-Arabic speakers, in their minds, as they did not receive it in an understandable accent or language. They believed that patients tend to memorise information better when it is presented in clearer or "more correct" Arabic.

6.4.3 IMGs' approaches to advising patients

It has been noted that some IMGs were able to come up with new and acceptable strategies to help patients control their diabetes. They realized the importance of certain foods to their patients and adopted strategies to ensure that they could continue to consume them in a healthy way, in addition to finding ways to help them be physically active within the

154

framework of their culture and everyday habits. On the other hand, despite their familiarity with cultural norms, local diets and food customs, a small number of the IMGs were inflexible in their advice. They were resigned to the fact that patients would not follow their advice and therefore did not make much effort to advise patients in this regard. For example, while some IMGs advised patients to avoid eating dates completely, as exemplified by this quote:

"I tell them "do not eat dates". Even three pieces may affect your sugar level"

[Translated]

(IMG16, Egyptian)

Other IMGs advised patients to reduce their date intake because it is not as harmful for diabetes patients' health if it is taken in limited amounts:

"This is not a bad food also, just reduce the amount" [sic]

(IMG19, Pakistani)

The first quote exemplifies inflexible advice, while the second indicates that the physician tried to advise patients in culturally acceptable terms.

Those who adopt an inflexible strategy in terms of giving advice might feel compelled to do so because of the administrative pressure on consultation times, knowing that adopting a more flexible approach takes time for IMGs to apply. For example, one IMG from Pakistan reported that his colleagues and administrators in the centre blame him because he spends more time with the patients compared to other physicians in the same centre. He noted:

"I have this problem here from my staff, my colleagues, and my administration also. That you are giving too much time to the patients; we don't want patients sitting outside [...] if the doctor finishes in half an hour…what can he offer?!"

<p align="right">(IMG19, Pakistani) Follow-up interview</p>

The IMG however, defensively expressed the opinion that this pressure from the administration did not affect the quality of his performance and would not prevent him from exchanging information properly with his patients.

Additionally, according to one IMG, IMGs are assumed by their patients to be unfamiliar with the culture, which make some IMGs adopt inflexible approaches in dealing with their diabetic patients. According to her, these IMGs care more about completing paperwork by following the guidelines for treating T2DM than their patients' actual needs. She also added that IMGs could be put-off by patients' non-compliance as she explained:

"When you are working at a place which doesn't belong to you, so at time you have the attitude, "Whatever happens to these people, I have to do my work [...] this might be because of the attitude of the patient. Maybe at the beginning they try to convince the patient, but maybe they were not professionally skilled to communicate properly with the patient, or the patients were really arrogant with them. So they say "To hell with everything. I have tried all my strategies but none is working, so let them do whatever they're doing, and I'll do whatever I want to do." [sic]

<p align="right">(IMG18, Bangladeshi)</p>

Another challenge to providing flexible advice was the IMGs' idea that managing T2DM is the responsibility of the patients themselves. One IMG believed that T2DM patients do not need detailed advice about diet and that they should find out how to manage to eat a healthy diet for themselves. This IMG, who demonstrated familiarity with the local diet, reported:

"I know they eat a lot of dates. But they should figure out how to work on that"

[sic]

(IMG10, Indian)

However, his poor Arabic language ability may also have influenced his approach.

Similarly, one patient believed that it was not the IMG's responsibility to provide dietary advice, believing that it was the patient's responsibility to evaluate their own food and decide what was healthy for them. He stated:

"If he [the IMG] asked me to reduce sugar intake, I should know what the sources of sugar in my food are and stop them or reduce them" [Translated]

(Patient 2)

This attitude was unexpected from a patient participant, but may be attributed to the patient's view on IMGs in general, as patients believe that people who do not share the same language and culture may not be able to provide appropriate information. It could also be attributed to this patients' level of education, as his responses reflected good knowledge about diabetes and its management.

An Indian IMG with 4 years experience working in SA provided the following example of the difficulty of communicating information:

"When I talk to you in your mother tongue in your own dialect, you would understand more than if I talk in a weird accent, even if it's your own language" [sic]

<div align="right">*(IMG10, Indian) follow-up interview*</div>

As expected, language appeared to be an obstacle to adopting a flexible approach, as sometimes IMGs, especially non-Arabic speakers, were not able to express themselves to their patients, as mentioned earlier in 6.2.1.

On the other hand, IMGs who had a flexible approach to advising patients acknowledged that it could be difficult for patients to follow their advice so they modified their approach to better suit the culture of the community. For example, IMG 15 advised her patients to cut each date to four pieces so they can feel that they ate larger amount of dates. According to them, the ability to do this develops with more experience in interacting with Saudi patients. In the words of one IMG:

"Both [IMGs with both strategies] do their best. There are differences in the knowledge of how culture is deeply rooted in the Saudi community. Doctors with more experience can give more practical advice than doctors with less experience, who will eventually change with time, when they see less compliant patients and speak to them" [translated]

<div align="right">*(IMG11, Syrian) Follow-up interview*</div>

This IMG, along with other IMGs, believed that those who follow a flexible or inflexible approach are doing their best to deliver the optimum care they can deliver within the limitations of their skills.

Providing general advice without paying much attention to cultural specifications was believed by one IMG to be the best way of advising patients. This may explain why some IMGs who adopt an inflexible approach believe that they are helping their patients. As one IMG commented:

"I just tell them the main things that you should stop is the sweets. You should stop the bakery items. You should take tea or coffee, if you were taking without sugar in moderation and continue rest of the things [...] if you say you just eat this, this, this, this, this, they think that we are getting this restricted things to eat? But if you say just restrict these things and eat everything, then they will think that there are lots of options available for us" [sic]

(IMG18, Bangladeshi)

The belief that handling one's health condition is the absolute responsibility of the patients, and pressure from the administration to finish their clinics on time were some of the proposed reasons given by the IMGs for adopting a more inflexible approach to advising patients regarding their lifestyle. Patients' preconceived ideas about their physicians, IMGs' inability to communicate information and the lack of the experience needed to enable them both to provide culturally sensitive advice and alternatives to the standard lifestyle advice, may result in patients acknowledging neither their IMGs' knowledge, nor their ability to provide culturally sensitive advice. Additionally, rather than considering providing inflexible advice to patients to be poor practice, in their follow-up interviews, the majority of the IMGs expressed the view that inflexible or more flexible strategies when advising patients were adopted, according to what they felt worked best for this specific community.

159

6.4.3.1 The effect of IMGs' stereotypical views towards patients on the provision of lifestyle advice

Because IMGs' stereotypical views appeared to directly affect IMGs lifestyle advice, it will be discussed under this theme.

Most of the IMGs who took a more inflexible approach towards advising patients appeared largely to believe that the nature of living in SA would restrict people from following their advice. In a country such as SA, where the only entertainment is in social gatherings, restaurants are found in abundance, food is cheap and people do not exercise, advising patients about changing their lifestyles was frequently judged by these IMGs to be pointless. For example, one IMG noted:

> *"We cannot combat it because people have too much money to spend. Food is very cheap they can take as much as they want [...] so it is destined to be a failure. It is a futile exercise" [sic]*
>
> *(IMG3, Kashmiri) Focus group interview*

Some of the patients also reported that they had not received advice about exercise, merely dietary advice. This can also be attributed to the fact that IMGs may have a preconceived idea that Saudi patients tend to have a sedentary lifestyle, which makes advising them in this regard ineffective. One IMG noted:

> *"This is one of the difficulties also, getting patients to exercise [...]. We have sedentary lifestyle; most of the Saudis are not used to exercise"*
>
> *(IMG9, Pakistani)*

IMGs' perception of the needs of their Saudi diabetes patients could also lead to adopting an inflexible approach to giving advice. A small number of IMGs believed that patients'

160

main goal when visiting their physicians was to obtain diabetes medication. In other words, they did not assign the same value to the advice they received from their doctors regarding lifestyle changes. An IMG explained:

"The patients' main concern is taking their medication. They feel that this is the most important thing in managing the disease. Even if I tell them that all these factors [related to lifestyle] are equally important in order to manage their condition, they would stress on taking medication, as if the medication will cure them completely from diabetes" [Translated]

(IMG7, Sudanese)

In general, the IMGs' stereotypical views of their patients' lifestyles and needs from the medical interview may negatively affect the quality of care they provide to local patients.

6.4.4 Summary

In summary, misinterpreting patients' needs meant that some IMGs did not consider culture in their approach to advising patients with regards to changing their lifestyle. However, the majority of the IMGs showed good familiarity with local cultural norms in relation to lifestyle, and gave examples that showed their ability to provide culturally sensitive lifestyle advice. Despite this, however, patients did not always acknowledge IMGs' ability to provide culturally sensitive advice, for reasons related to language and cultural differences. Last but not least, it should be noted that despite appropriate education, these culturally and environmentally determined habits are widely understood to be relatively difficult to change through individual education and support, unless there are also changes in social and cultural norms.

6.5 Practical strategies used by IMGs and patients to facilitate communication

This theme discusses some strategies already adopted by the participants to combat the challenges presented in the previous sections and presents participants' suggestions to facilitate IMG-patient communication. Two main subthemes in this section are: adopted strategies to overcome barriers to effective IMG-patient communication; and suggested strategies to facilitate IMG-patient communication. The former subtheme presents participants' experiences in applying self-adopted strategies to overcome communication challenges, while the latter presents participants' suggested strategies for higher authorities from the PHCCs and the MOH to implement in order to facilitate IMG-patient communication.

6.5.1 Adopted strategies to overcome barriers to effective IMG-patient communication

It emerged from the findings that the IMGs and the patients were trying to find ways to facilitate communication and interaction with each other. Six strategies emerged that had been adopted by both IMGs and patients and, according to the participants, helped them in improving communication and interaction. Adopting these strategies stemmed from their desire to improve communication with each other. These strategies were as follows: communicating in a common language; non-verbal communication; written information; social conversations; using religious expressions; and reliance on other health care professionals.

6.5.1.1 Communicating in a common language

It was apparent from the patients' responses that they were aware of the fact that all IMGs can communicate in English. Although most patients, especially those older ones who had never been formally educated, were not expected to speak English, a small number of the patients interviewed tried to communicate with their physicians with the little English they knew, as a strategy to facilitate interaction. Nonetheless, their attempts did not necessarily lead to the intended goal. For example, one patient noted:

"I speak poor English and I don't always understand what he [the IMG]

intends to say, I don't know how to express myself" [Translated]

(Patient12)

Another patient reported several attempts to communicate with his Pakistani physician in Urdu, as he learned it from some workers at his own garage. According to him, understanding was achieved using Urdu, as he explained:

164

"I also learned some Urdu from the workers [in his garage] and I did use it

several times to explain things to my doctor. So yes, I can get away with that

but some people cannot do that, you know, not all people speak Urdu!"

[Translated]

(Patient9)

Furthermore, one IMG explained that patients might change their accent imitating IMGs to facilitate understanding. He asserted:

"They even talk with; you know this foreign accent to make me understand. They

help yes. Some of them do yes, yes" [sic]

(IMG14, Pakistan)

In general, patients' attempts to communicate in a common language are a positive and valiant attempt at trying to communicate. However, these strategies could have unintended consequences in terms of actually making communication more difficult, because they may increase the chances of misunderstanding, as both parties are trying to communicate in a language other than their own.

6.5.1.2 Non-verbal communication

Non-verbal communication was one of the strategies most of the IMGs and patients used to facilitate understanding.

The majority of the IMGs and patients thought that hand gestures and facial expressions are "international" and can deliver the message when verbal communication is limited as a result of physician-patient language discordance. For example, one patient shared her experience with a newly-arrived IMG from Pakistan. She was afraid that being prescribed a

new medicine by her previous physician caused the palpitation she had started to feel. She struggled to express her concerns, but she was understood by the IMG when she used signals and sounds to demonstrate her symptoms, as she explained:

"I pointed at my heart and said "tick, tick, tick!" then she finally understood

that I had palpitation!" [Translated]

(Patient7)

An IMG reported that she even stood up and simulated doing exercises to explain to her patients what to do and how to do it, as verbal explanation had been difficult for her to achieve. She noted:

"At times explaining the exercise is difficult for me, to the patient. So what I

do, I do the exercise in front of them" [sic]

(IMG18, Bangladeshi)

According to the majority of the IMGs, non-verbal communication actually helped them to understand their patients and to be understood by them. According to an IMG who had 4 years' experience of working in SA,

"...Patients try to explain to me their problem and I link words with signs and

facial expressions and come to know that [...] I rely a lot on that. I use it myself to

explain. They say pain and make this sad face or shake their hands like this and

point to the...where the pain is" [sic]

(IMG14, Pakistan)

On the other hand, one Pakistani IMG believed that understanding what is beyond the language is important and cannot be detected by hand signs and gestures. He believed that patients' feelings and emotions could be difficult to detect, compared to patients in his own

country, because the local patients do not share the same cultural background as him. He stated:

"You get not just the words of what the patient [Pakistani patient] is saying but the feel ... You know about the feel of the word. You feel what he's trying to say" [sic]

<div align="right">

(IMG9, Pakistani)

</div>

In general, most of the non-Arabic speaking IMGs and T2DM patients resorted to non-verbal communication to facilitate understanding.

6.5.1.3 Written information

Most of the IMGs supported the use of written information, such as the brochures and booklets that are provided by the Medical Education Department in the MOH to all PHCCs. These are usually written using simple non-medical Arabic for patients of all backgrounds. Illiterate patients have to rely on their physicians to receive information, as they are not provided with a specific source of information.

The IMGs found using written information helpful to deliver information if they could not do this for reasons related to their language or cultural knowledge. As one IMG commented:

"If the physician is not able to deliver the message, these brochures can help" [Translated]

<div align="right">

(IMG13, Egyptian)

</div>

Non-Arabic speaking IMGs found the written information provided particularly useful, as they might not be able to explain some details about the disease or provide appropriate advice because of their limited language ability. For example, when an IMG from Pakistan

was asked about her ability to give detailed lifestyle information to her Saudi patients with T2DM, she responded:

"I cannot go to that extent. I told you; I give them brochures and tell them the main things"

(IMG14, Pakistani)

Nonetheless, as some IMGs do not speak or read Arabic, their familiarity with the information written in Arabic that they are providing their T2DM patients with may be limited. The follow-up interviews showed that, whilst it was clear that the Arabic speaking IMGs read and understood all the information written in the booklets, it was also true that the non-Arabic speaking IMGs made some attempt to understand these materials, either by getting them translated by colleagues from their PHCC or relying on the words that they already knew and trying to make sense of the other sentences, as described in this quote:

"I know some of what is mentioned in these brochures [...] few words, so it adds up to the same meaning" [sic]

(IMG10, Indian) Follow-up interview

This IMG denied that he needs these written materials to be translated for him, he explained:

"I understand what I give my patients! [...] I try to translate it to myself. I didn't write it down! I understood what it says" [sic]

(IMG10, Indian) Follow-up interview

His denial however, can be attributed to avoiding being judged by the researcher, as it seemed that he was defensive when questioned about reasons for not getting the written materials translated for him.

Other IMGs may rely on the images in the booklets to assist them in familiarising themselves with the information provided. One IMG explained:

"I cannot say I know every word of these things. But things like this pyramid because these actually these were taken from our medical books we know them. All these pictures I know [...] from first look we know what this is saying" [sic]

(IMG19, Pakistani)

It also appeared that patients might rely on these brochures as they accept that their IMGs may not be able to deliver information. For example, one of the patients felt that being given brochures by his Pakistani IMG is the best way to get information about diabetes, as his doctor is not fluent in Arabic.

In general, non-Arabic speaking IMGs rely on written information as a strategy to help them provide their patients with general information regarding their health condition. Nevertheless, this strategy may exclude illiterate patients, who cannot benefit from written information without others' help.

6.5.1.4 Social conversations

Although some IMGs already adopted a formal relationship with their patients (see section 6.3.2), they have reported some attempts to "break the ice" and involve patients in non-health related conversations as a strategy to improve the relationship and build rapport with their patients. These attempts were mostly adopted by the Arabic speaking IMGs, especially Egyptian physicians. For instance, one IMG explained:

"Initial communication with patients is very important to reduce their fear and make them feel that you are close to them" [Translated]

(IMG8, Egyptian)

169

Some IMGs use the differences between themselves and their patients as a starting point to open a conversation aiming to improve their relationship with them. An IMG from Egypt explained that she asks patients about their culture and food habits and she has noted that they are delighted to pursue conversations about these topics, she noted:

"I was excited and really want to know about culture and food. I asked the patients and they were nice. They speak about it in detail [...] It is always exciting to talk about these things and patients can be easily involved in such conversations, we can take it from here" [Translated]

(IMG16, Egyptian)

Another IMG used the political situation in his country, Egypt, to facilitate building relationships with patients. Additionally, he takes this as an opportunity to present his opinions in a way that can engage patients aiming to attain their trust, as he explained:

"Sometimes, especially nowadays, being Egyptian helps me to open a conversation. Patients ask about the political issues we have now and they actually sympathize with me as an Egyptian. Sometimes we negotiate and talk at length in this regard. This helps in building the relationship and gives the patient an opportunity to notice my critical thinking and this also may help in building trust" [Translated]

(IMG13, Egyptian)

Nevertheless, although being different from their patients may contribute in facilitating relationship building, IMGs are also aware that not sharing the same culture as their patients can contribute to creating distance between them. This can make rapport and relationship building with their patients more challenging. For example, not being familiar with local

events contributed to making IMGs sometimes struggle to find common interests with their patients as a way of starting social conversations. The same IMG explained:

"Being non-Saudi also may keep me distant from what is happening in the country, for example, football matches, exam times... I know that knowing these things may help me to gain patients' attention and strengthen the bond between my patients and I" [Translated]

(IMG13, Egyptian)

A small number of the IMGs expressed the feeling that maintaining a formal relationship helped them to focus entirely on the treatment and not be distracted with non-health related conversations. One IMG from India, who did not support building rapport with patient, considered social conversations with patients a waste of the consultation's time. He stated:

"They [Saudi patients] might mention totally unrelated things for the sake of talking. And you don't have time for that [...] this might be good. Yes it might be good to focus on the main problem that they came for" [sic]

(IMG10, Indian)

In general, some of the IMGs used cultural differences to strengthen the relationship with their local patients, while acknowledging that coming from a different cultural background may also create a distance between them and their patients.

6.5.1.5 Using religious expressions

Most Saudi people are strongly attached to their religion, Islam. In some cases, they tend to use religious expressions to express their strong faith in Allah. Some of the IMGs used this information to improve compliance and build trust and rapport with their

patients, as they believe that involving religious beliefs encourages trust and hence patients may become more motivated to follow their advice.

The IMGs acknowledged that the application of Islamic teachings in SA is different from other parts of the world, as it follows the Wahabi system. One IMG noted:

"People here are not like most other Muslims in the world, they are conservative" [Translated]

(IMG12, Sudanese)

It appears from the findings that a small number of the IMGs were aware of the importance of including religious aspects when dealing with their Saudi patients in order to build rapport with them. Using Islamic expressions that are widely used among Saudi people seemed to make IMGs appear more trustworthy and acceptable to local patients. According to one IMG:

"I did not used to say "Inshallah" [if God wills] and "Alhamdulillah" [Thanks to God] that often, but now I use them a lot because patients use them and trust you if you put everything under God's will at the end of the consultation" [Translated]

(IMG11, Syrian)

The same IMG explained that she changed her way of dressing to be more modest to avoid being judged by her patients if they saw her outside the healthcare premises. She explained:

"Being misjudged by patients may affect trust between my patients and I. People here are very connected to their religion, which is good of course, so I know by looking decent and religious, by their definition, I can be more

172

connected to them and they will consider me good, respectable and

trustworthy" [Translated]

(IMG11, Syrian)

Another IMG used some Islamic teachings to encourage his patients to follow his advice.

He summarised a conversation between himself and a patient as follows:

"Because I know, because we are seeing patients with diabetes, so we know

what works and how to talk to them. Like I say "listen brother, eating dates is

Sunnah, that is not obligatory in Islam, but treatment is", "yes!", "are you

going to do the non-obligatory things and avoid what you have to do?", "I do

obligatory things first" [sic]

(IMG1, Pakistan) Focus group

Here, the IMG was convincing his patient to avoid eating dates using Islamic teachings,

which separate instructions into mandatory ones from Quraan, and optional, that is, from

Sunnah. It needs to be noted that, for the IMG to be able to use Islamic teaching in

advising their patients, they either have to be Muslims or be well acquainted with these

teachings.

To sum up, it appeared that some of the IMGs followed a strategy to build rapport with

their local patients and convince them to follow their advice by using religious teachings.

These efforts ranged from changing their clinical approach when advising patients, to

changing their external appearance in order to conform to cultural norms.

6.5.1.6 Reliance on other health care professionals

One of the strategies that the IMGs found helpful to overcome the communication barrier

was the use of the expertise of other healthcare professionals by depending on them to

deliver the advice or the medication prescribed for patients. For example, IMGs, especially those who worked in the hospital, often checked if a Saudi or an Arabic-speaking physician had seen the patient before they did. This was considered an advantage because it was likely that the Arabic-speaking physician had already explained the disease and its consequences to the patient. The IMGs then did not have to struggle with the language in order to provide information. One IMG commented:

"I think they [non-Arabic speaking IMGs] are aware of their language ability so they know that they would never present the advice better than an Arabic speaking expatriate doctor" [Translated]

(IMG11, Syrian) Follow-up interview

Another strategy used was writing the prescription and then depending on the pharmacist to provide patients with information about the medication and how to use it so they did not have to struggle with language issues to deliver the message. For instance, a non-Arabic speaking IMG from Pakistan explained:

"I write the prescription and the pharmacist does it [the explanation], all the ladies in the pharmacy here are Saudis" [sic]

(IMG14, Pakistani)

In general, relying on other health care professionals to convey information reflects IMGs' insights into the importance of providing appropriate information related to patients' health condition and medication. It seemed appropriate to IMGs to use all the resources they could to provide such information. However, IMGs, especially those with poor language abilities, might not be familiar with the exact information given by previous physicians, as they tend only to ask their patients whether they have been seen by an Arabic-speaking IMG or not,

174

without enquiring about the information they received from their Arab physicians, to be able to compare it to their own or amend it, in case they need to.

6.5.2 Suggested strategies to facilitate IMG-patient interaction

The IMGs and patients presented some suggestions to facilitate the process of IMG–patient communication and interaction. These were mostly suggestions that they did not yet implement to facilitate their current communications. Instead, these were suggestions that could potentially be applied by higher authorities at the MOH to improve IMG-patient communication. Findings in this theme revealed four main subthemes, which are: using interpreters; courses in language and culture; sharing experiences; involving PHCCs' administrations.

6.5.2.1 Using interpreters

As PHCCs in Saudi are not equipped with interpreters, physicians and patients tend to use informal help from colleagues at the centre, or family and friends, as facilitators to communication. For instance some of the non-Arabic speaking IMGs reported enlisting the help of nurses, colleagues or family members of patients, especially younger family members who may speak better English than patients, to translate for them. A non-Arabic speaking IMG, who showed good familiarity with the Arabic language, noted:

"The colleagues usually act as translators. If I need a translation I ask one of my Saudi colleagues […] sometimes one of the family members may be of the younger generation that know more English […] I used a lot of people to

translate. The nurses that have been here for a long time, they know the

language better than I do" [sic]

<div align="right">*(IMG9, Pakistani)*</div>

One of the drawbacks of using colleagues as interpreters, as per the latter IMG, is imposing on their time and sometimes waiting for someone to be available.

Another Arabic-speaking IMG reported that even Arabic-speaking IMGs might need interpreters' and family members' assistance during the medical consultation because some older Saudi patients often speak in a dialect that is difficult for the IMGs to understand:

> *"Arab physicians can deal with the dialect if a younger family member is there.*
>
> *Patients understand me, but I do not if they speak with a strong dialect"*
>
> *[Translated]*

<div align="right">*(IMG12, Sudanese)*</div>

The findings showed that views on using interpreters varied. For example, a large number of the IMGs and all the patients included in the study believed that the presence of an interpreter would improve the quality of the consultation by making it easier for physicians and patients to understand each other. They felt it would make patients better able to express themselves freely, without worrying about language differences. An IMG expressed her views on the presence of an interpreter during the consultation:

> *"I feel everything is under control. I understand the patients and they*
>
> *understand me as well. They start to speak more when there is someone to*
>
> *interpret" [sic]*

<div align="right">*(IMG14, Pakistani)*</div>

One of the patient participants believed that all the difficulties in communicating with IMGs would be solved if interpreters were available. She asserted:

"This will definitely help. Then we can both be relaxed and the consultation will go well. Communication is all what we want. Everything can be solved if we can exchange information and the presence of an interpreter serves that" [Translated]

(Patient7)

On the other hand, three of the IMGs, including both Arabic and non-Arabic speakers, believed that using interpreters did not guarantee delivering the intended meaning, as this could be lost and information may change during the process of translation. One IMG, who noted enlisting colleagues and patients' family members in translation, stated:

"... You will not get everything. Some things will get lost in translation" [sic]

(IMG9, Pakistani)

Furthermore, two of the Arabic-speaking IMGs felt that the presence of an interpreter between physicians and patients, although it may help in delivering the message, may negatively affect rapport-building as direct communication between them can be limited. For instance, an IMG from Jordan reported that:

"The doctors will never build a strong relationship as long as there is an interpreter. They are not communicating with each other directly! But technically it works" [Translated]

(IMG17, Jordanian)

It should be noted that this quote came from an Arabic speaking IMG who obviously would not need an interpreter and did not experience the frustration of communicating in a different language.

The same IMGs considered describing feelings and emotions in the presence of interpreters as a difficult experience. On the other hand, one of the patients reported that feelings could not be missed as expressing them involves non-verbal communication, which can be detected easily by physicians. She explained:

> *"The doctor and the patient will not miss emotions and body language, these*
> *are things that can be felt and seen as long as they are in the same room. These*
> *things do not have to be transferred verbally" [Translated]*

(Paient1)

Overall, it appears from the findings that the patients and the IMGs felt they would benefit from interpreters to facilitate communication, despite the fact that some of the latter believed that meanings could be lost in translation. Some Arabic-speaking IMGs felt that the presence of an interpreter during a medical consultation might act as a barrier to building rapport between IMGs and patients.

6.5.2.2 Courses in language and culture

The majority of the IMGs suggested that the MOH should organize Arabic language and Saudi culture courses to facilitate communication and interaction between them and their Saudi patients. They felt that this would be an investment for the benefit of patients, and could eventually lead to better care provision. For instance, an IMG from Pakistan noted that:

178

"If there is a new expatriate doctor to come they must invest in the time to learn the language properly [...]. Patients they will be more satisfied. The doctor is speaking in a good language, language that they understand. I think this is very important" [sic]

<div align="right">

(IMG9, Pakistani)

</div>

Courses in culture were another idea that was suggested to improve communication. One IMG summarised his suggestion of the courses contents, stating:

"...Language, inform doctors about places to exercise, if the doctor is not Muslim he should be informed about fasting in Ramadan and how to advise patients during this month and prepare them for it" [Translated]

<div align="right">

(IMG13, Egyptian)

</div>

Although it is uncommon to find non-Muslim IMGs at community-based PHCCs, one Muslim IMG suggested giving special attention to non-Muslim IMGs in regards to advising patients by equipping them with the appropriate information. This IMG stated:

"there are foods and drinks that are forbidden in Islam. If we assume the doctor isn't Muslim, he would talk about alcohol asking patients to stop drinking it. This advice is based on medical and scientific viewpoint. This is just an example. However, establishing a link between the medical and the religious aspects strengthens the piece of information and medical advice and makes the patient more inclined to follow through with the prevention and treatment" [Translated]

<div align="right">

(IMG17, Jordan)

</div>

Some other IMGs suggested distributing written materials to newly-arrived IMGs to help them to understand the culture. One IMG believed that written information is more convenient for IMGs, noting that:

"If there is a booklet made by one expert from the Ministry of Health or health education system, maybe 200 hundred pages like this […] to describe the culture in some programmes or in some books something like this. It is, I think, more easy; more convenient; and more quick to adopt." [sic]

(IMG19, Pakistani) Follow-up interview

A number of the patients and the Arabic-speaking IMGs voiced their dissatisfaction with the selection criteria for IMGs. They suggested the MOH should consider language competence as one of the criteria and they gave Western countries as an example of good practice because they require their IMGs to undergo language evaluation before working in their countries. An IMG noted:

"I also suggest changing the requirement for recruiting physicians to involve language efficiency. This is very important" [Translated]

(IMG11, Syrian)

Another patient noted:

"The MOH should not even bring a physician before they make sure he speaks Arabic" [Translated]

(Patient3)

Non-Arabic speaking IMGs did not comment about changing IMGs' selection criteria to include language ability, presumably because they benefitted from the existing criteria.

180

In general, it appeared that IMGs would feel empowered by receiving courses in language and culture, to improve their ability to communicate with their patients, build confidence, avoid being misunderstood, and be better able to conduct medical interviews.

6.5.2.3 Sharing experiences

A small number of the IMGs recommended arranging meetings with more experienced colleagues in order to allow newly-arrived IMGs to benefit from their experiences. In this way, they could share their experiences of, and strategies for providing advice, gaining trust and dealing with difficult patients, as well as information about the mentality and culture of the Saudi community. According to one IMG:

> *"They should meet with other foreign physicians with more experience to talk*
>
> *to them about the nature of this society, how they think, how to provide advice,*
>
> *how to deal with difficult patients and how to gain patients' trust" [Translated]*
>
> *(IMG12, Sudanese)*

Sharing experiences with more experienced IMGs, rather than Saudi physicians, was considered to be most useful, as the same IMG noted:

> *"An experienced foreign physician should do that because Saudis might not*
>
> *appreciate local customs and habits that affect diabetes like outsiders do"*
>
> *[Translated]*
>
> *(IMG12, Sudanese)*

One IMG suggested that newly-arrived IMGs should begin by observing more experienced physicians and then withdraw gradually until they are able to run a clinic by themselves:

"Newcomers can also attend the clinic as observers with doctors who are more experienced for the first 2 or 3 months […] Then gradually, they can take six patients a day and the number builds up slowly" [translated]

(IMG13, Egyptian)

By sharing experiences with other IMGs, some of the IMG participants thought that newly-arrived physicians would be better able to adapt to the new system and people.

6.5.2.4 Involving PHCCs' administrators

Two of the IMGs felt that patients may not be comfortable entering the clinic to find a new IMG waiting to see them, particularly since appropriate interaction and rapport building with IMGs can take longer than with Saudi physicians, which may make IMG-patient interaction and rapport building a difficult task. However, if someone from the PHCC's administration or another more experienced physician was there to introduce the newly-arrived IMG to patients, this could control patients' superiority and facilitate patients' acceptance of that IMG, as it would send a clear message to patients that this IMG is supported by the administration. One IMG commented:

"The supervisor should introduce new doctors to the patients. They suddenly open the door to find me, a new doctor, and want to control me. If she [the supervisor] introduces me they would know that I am supported by the administration, they would respect me and I will be comfortable" [sic]

(IMG14, Pakistani)

Being supported by the PHCCs' administration may empower the IMGs and relieve them from feeling insecure about their jobs when they try to deal with any prejudice they may face.

Another IMG suggested that Saudis working in the PHCCs should take responsibility for introducing them to their patients. She believed that this could be a way to change patients' perception of IMGs, as she noted:

"It's the professional people from Saudi, they need to change the perception of the patients. Patients can never change their perception"

(IMG18, Bangladesh)

In general, according to some IMGs, it seems that the idea of recruiting a member of the administration to introduce newly-arrived IMGs may enable the latter to feel more supported and secure, and this may give them the confidence to get through the process of rapport-building.

6.5.3 Summary

In summary, in order to improve communication and interaction between IMGs and patients, the participants both identified strategies for doctors and patients and identified potential measures that needed the support of policy makers or the clinic's administration. It appears that most of the strategies emerging from the findings that IMGs and patients have used revolved around overcoming linguistic and cultural challenges and empowering IMGs to be better able to effectively conduct medical consultations.

Chapter 7

Discussion

7.0 Introduction

This study has explored the experiences of IMGs when delivering care to local patients and of Saudi patients with T2DM receiving care from IMGs. The aim of the study was to identify and understand possible facilitators and challenges to cross-cultural communication faced by IMGs and local patients in SA. The importance of exploring this issue lies in the fact that most physicians who work in SA are IMGs (MOH, 2012) who do not share the same culture and language, or dialect as their local patients. T2DM was chosen as an example to demonstrate their experiences, as it is a prevalent chronic health condition in SA, which needs long-term follow up by general practitioners and requires lifestyle modifications that are culturally defined.

The first part of this chapter highlights key findings and the original contribution to knowledge in the field represented by these findings. These findings are then discussed in detail in the context of other literature using the following themes: IMGs' language and cultural competency; patients' attitude towards IMGs; the effect of prejudice on care provision; strategies to overcome language and cultural barriers and support systems.

The second part of the chapter outlines the strengths and limitations of the study; implications for policy and practice and future research priorities. The final section

summarises the overall contribution of this study and the implications for provision of more effective health care in SA.

7.1 Key findings in relation to the research questions

The current study is the first study aiming to understand cross-cultural medical care in SA. Comparing the perspectives of both IMGs and patients has contributed in showing a mismatch between IMGs' and patients' expectations which may have a detrimental impact on the quality of care if due consideration is not given to the needs of both physicians and patients. This study found that effective use of cultural competence theory to inform practice requires consideration of patient as well as professional understanding and attitudes in dealing with patients from different cultures. Training physicians to become culturally competent without paying equal attention to improving patients' attitude towards their physicians may not lead to the intended overall results sought from these programmes.

Identifying challenges and facilitators to cross-cultural medical communication is required to achieve good patient-physician relationships and target efforts to improve the quality of health care appropriately. The study has identified some sensitive issues regarding patients' attitude to IMGs and recognized some weak links in the system that hamper the provision of quality health care by IMGs in SA. For example, it identified the existence of prejudice in the cross-cultural medical encounter and lack of support system for IMGs. The lack of effective communication between IMGs and patients, as a result of language and cultural differences, has led to the persistence of IMGs' approaches to patients, despite patients' lack of satisfaction with these approaches, for example, dealing formally with patients and avoiding explicit SDM.

Furthermore, the study has identified a number of barriers and facilitators to effective cross-cultural communication between IMGs and local patients with T2DM in SA.

Cultural differences between IMGs and patients, in addition to some IMGs' limited awareness relating to Arabic and its dialects, were identified as critical issues that negatively affect the quality of care. Cultural discordance lead to prejudice and stereotyping amongst local patients towards IMGs, and vice versa, and the current study identified that these were important factors influencing their relationship and communication. For example, most patients did not acknowledge the IMGs' knowledge and ability to provide appropriate lifestyle advice to local patients with chronic diseases, for reasons related to language and prejudice, which were in turn found to be related to the local culture. IMGs' stereotypical view of local patients made some follow inflexible approaches in advising patients. For example, advising patients not to consume dates.

Moreover, the lack of appropriate support systems for IMGs added to the difficulty of IMG-patient communication and hampered effective communication and hence effective medical care, due to the nonexistence of training and interpretation services that target IMGs.

Furthermore, the current findings showed that patients refrained from disclosing health-related information to IMGs if they believed that they might not be able to assist them because they come from a different cultural background. For example, the current study showed that patients might not wish to share information about using herbal remedies to treat their own health condition, as using alternative medicine is deeply rooted in the culture, and they believe that IMGs may find it difficult to advise patients in this regard. However, patients' safety might be compromised if thorough information about their health practices is not disclosed to their physicians.

IMGs and patients identified self-adopted strategies to overcome certain barriers to effective communication, such as using facial expressions and hand signals to express the intended meaning. In addition, written information, including booklets and brochures, written in Arabic, were often given to patients by non-Arabic speaking IMGs who were not usually familiar with their contents. The need to improve written information to be more culturally appropriate was identified.

7.2 Discussion of findings in relation to previous research

Through the use of qualitative, in-depth interviews to explore the experiences of IMGs and local patients with T2DM, this study has identified some important challenges influencing the quality of care provision in SA. In this section, the key findings outlined above are discussed in relation to the wider body of cultural competency literature.

7.2.1 IMGs' language and cultural competency

The current study found that the IMGs' unfamiliarity with Arabic, in addition to cultural differences between them and their patients were dominant issues affecting IMG-patient communication and subsequently influencing other aspects of care, such as the provision of health-related advice.

7.2.1.1 Language as a barrier to cross-cultural medical care

The qualitative studies from the US and Australia have acknowledged language and dialect as barriers to effective communication between IMGs and patients (Fiscella *et al.*, 1997; Dorgan *et al.*, 2009; Dahm, 2011; Jain and Krieger, 2011). As in previous studies (Dorgan *et al.*, 2009; Dahm, 2011), IMGs in this study experienced some difficulties understanding the local language and dialects. However, unlike IMGs in most other

countries, IMGs in SA are not required, as a selection criterion, to speak Arabic. As a result, the influence of ineffective communication could be manifested more than that, for example, in the US (Dorgan *et al.*, 2009) and Australia (Dahm, 2011) where IMGs are required to speak the local language.

The IMGs in SA found themselves struggling alone to communicate with local patients. Some of the IMGs explicitly described their helplessness and inability to communicate the basic information required to conduct medical interviews. As a result, poor communication and hence poor quality of care was to be expected.

Arabic-speaking IMGs, for example from Egypt, Syria and Sudan, speak different dialects from that spoken by Saudi people. However, Arabic-speaking IMGs were more able to find ways to understand their patients. For instance, they were able to ask patients about unfamiliar words or use traditional Arabic, which is understood by most Arabic speakers, to reach mutual understanding. Because the researcher speaks Arabic, during data collection, she was able to look on the Internet for some herbs that were used by the patient participants. This suggests that Arabic speaking IMGs would be able to search on the Internet for names, such as herbs, which they were not familiar with in the local dialect, and were therefore better able to provide appropriate advice.

The unique situation in SA, where IMGs' basic knowledge of the local language is not required by the MOH in order to recruit them to work in hospitals and PHCCs, has a great influence on both the IMGs' ability to provide care for local patients with T2DM and on patients' satisfaction with care provision.

7.2.1.2 Cultural competence in cross-cultural medical care

Dorgan et al. (2009), Dahm (2011) and Jain and Krieger (2011) showed that speaking the same language as that of the patients cannot overcome communication barriers if not coupled with understanding the culture, an example used in Dahm (2011) is, the use of the expression "tossing and turning", which was difficult for an IMG to comprehend. Most of the IMGs featured in the present study acknowledged that patients prefer to be seen by local physicians because they are better able to achieve rapport, as they share the same culture as the patients. This is consistent with findings from quantitative studies carried out in Iran and Australia, which found that patients prefer local physicians and perceived IMGs as less competent and trustworthy (Zeighami *et al.*, 1978; Louis *et al.*, 2010). The current study adds more detail to these findings about patients' perception of IMGs as less familiar with the Saudi culture, unable to communicate information and less able to understand their needs.

Unlike McDonnell and Usherwood (2008), who found that some of the IMGs in Australia struggled not to inflict their own cultural values, most of the IMGs in the current study showed some awareness of the Saudi culture and expressed their ability to provide culturally sensitive lifestyle advice regarding diet and exercise to local patients with T2DM, through giving examples. For instance, the IMGs were familiar with the places where patients could go to walk and with grocery shops where healthy food could be found. They also advised their patients regarding consuming dates, dealing with eating pressure during socialization and being physically active by walking to farther mosques, which are all specifically sensitive to the Saudi culture and religion. This advice-giving

reflects IMGs' awareness of the importance of providing culturally sensitive advice in improving patients' health and gaining their trust.

7.2.2 Patients' attitude towards IMGs

Almost all manual workers in SA are expatriates. Thus as mentioned in 1.5.1, local people generally consider expatriate workers to have low status. The following shows how local patients' views on IMGs influence quality of care provided by the latter.

7.2.2.1 Acknowledging IMGs' knowledge

Despite many IMGs' familiarity with the local culture and their apparent ability to provide patients with T2DM with culturally sensitive care, many patients did not acknowledge IMGs' cultural competency in care provision. The findings provided some potential reasons for patients' lack of acknowledgment of some of the IMGs' efforts to improve their communication and culturally-sensitive advising skills.

The inability of IMGs to communicate information to local patients was given as an explanation for patients not appreciating their IMGs' knowledge. Although IMGs demonstrated familiarity with and the ability to provide culturally appropriate lifestyle advice, in practice, some of them were not able to convey this information properly to their patients, for reasons related to language or dialects, which were noted earlier in section 7.2.1.1 as barriers to communication (Fiscella *et al.*, 1997; Dorgan *et al.*, 2009; Dahm, 2011; Jain and Krieger, 2011). Additionally, because some patients were not given the IMGs' advice in "familiar" Arabic, as some IMGs spoke 'basic' Arabic, they may not have remembered their advice, which could result in them not acknowledging their IMGs' cultural competence and consequently rating the quality of care provided by them more poorly.

Although most IMGs recognized that Saudi patients prefer to be seen by Saudi physicians, a small number of the IMGs featured in the current study, including Arabic and non-Arabic speakers, believed that local patients tend to prefer IMGs to local physicians. They attributed this preference to the meticulous selection criteria that they went through, which may suggest high qualifications to the patients, as well as less judgmental views over patients' behaviours and to their ability to keep the confidentiality of the medical interview. Similarly positive self-perception on the part of IMGs was not revealed in previous research on IMGs' views and experiences in caring for local patients (Fiscella *et al.*, 1997; McDonnell and Usherwood, 2008; Dorgan *et al.*, 2009; Dahm, 2011).

This positive self-perception of some IMGs contradicts most patients' perspective on the issue, in the current as well as in previous studies (Zeighami *et al.*, 1978; Louis *et al.*, 2010) where patients state they actually prefer local physicians to IMGs. Most of the patients in this study expressed a preference for Saudi physicians over IMGs. Therefore, while some IMGs may perceive their lack of familiarity with the culture and the local people as an advantage in terms of attracting Saudi patients, patients do not necessarily share this view. This may inadvertently motivate the IMGs to persist in showing their distance from the Saudi people and culture, which is then negatively perceived by patients and may influence their satisfaction with the quality of care.

This finding provides some potential explanation of how language and cultural distance between IMGs and patients may persist and negatively affect patients' perception of care, as identified previously by Fiscella et al. (1997).

7.2.2.2 Prejudice

The current study showed that prejudice and both positive and negative stereotyping occur in cross-cultural medical interactions in SA, where most of the local patients may negatively view IMGs and treat them as inferior, confirming the detrimental effect of prejudice on care provision. This view was not universal among the IMGs as some of the Egyptian IMGs and the patients positively viewed communication between Egyptian IMGs and local patients. Additionally, it is worth noting that most of the IMG participants who seemed more concerned about negative patients' attitude were females.

The study found that patients might present to their IMGs with a preconceived idea that they cannot provide culturally sensitive and practical advice, as they do not share the same culture as the patients. This assumption on the part of the patients may prevent them from fairly judging and acknowledging their IMGs' advice. Additionally, it influences their overall satisfaction with the quality of care they receive. Fiscella et al. (1997), Mcdonnell and Usherwood (2008) and Díaz and Hjörleifsson (2011) also identified the existence of prejudice between IMGs and local patients that was manifested by the IMGs' inability to recruit local patients due to their foreign names or patients' rejection of them based on their cultural background. The current study confirmed the existence of prejudice in the cross-cultural medical encounter; however this was manifested differently in SA. Here, some of the patients used the IMGs' apparent need to work in SA to improve their financial status, to stigmatise them. Additionally, some IMGs faced hurtful words and comments about their own backgrounds from local patients. Similar findings were found in Fiscella et al. (1997) where an IMG was faced

with negative comments about his accent and outfit because he came from a different cultural background.

The current study explored IMGs and patients' justifications for the existence of prejudice. For instance, participants were aware that as almost all manual workers, housemaids and private chauffeurs are expatriates, patients tend to relate being expatriate with inferiority and with uncritically obeying their commands. Regardless of the acceptability of this culture-related attitude, this attitude appears to influence the relationships between local patients and IMGs, where sharing information and listening to and discussing physicians' advice is important to improve patients' health.

Moreover, the patients' responses showed signs of prejudice towards IMGs. A small number of the patients explicitly expressed their preference to be seen by Saudi physicians. They attributed their preference of Saudi physicians to the familiarity with the culture. However, as noted earlier, many IMGs showed good familiarity with Saudi culture and most of them showed their ability to provide culturally sensitive advice to Saudi patients with T2DM. Thus, patients' views could be attributed to their prejudice towards IMGs.

In general, prejudice was found to be an attitude of local patients that significantly influenced IMG-patient relationships.

7.2.3 The effect of prejudice on care provision

The existence of prejudice amongst local patients towards IMGs negatively affects the quality of care provision, as demonstrated in the study findings in relation to the effect of prejudice on the patient-physician relationship. The presence of prejudice towards IMGs

is a sensitive issue that forms a significant barrier to physician-patient communication and relationship building.

It has been noted in this study that "looking down" upon IMGs is not always explicit in the cross-cultural medical interview. However, prejudice becomes more explicit in cases of misunderstanding or in cases where IMGs refuse to follow patients' wishes for reasons related to patients' health. An example could be the attitude of the patients (discussed in section 6.3.4) who wanted to be changed from insulin to oral hypoglycemic agents. It seemed that some IMGs were aware of this kind of attitude, regardless of their experience, which made them more formal in their relationship with local patients. IMGs' experiences with, and beliefs about, local patients' views on them may discourage them from providing optimal care, as building deeper relationships with the patients may expose them to explicit expression of discriminatory and prejudiced attitudes. Therefore, in order to achieve a balance between avoiding patients' explicit rejection, and providing care, IMGs tend to prefer to maintain formal relationships with patients.

A more formal relationship may also be a more superficial relationship where IMGs focus on patients' medical condition and do not pay equal attention to the psychosocial aspects of patients' care, which may require a deeper relationship to allow patients to disclose important information to their physicians. Findings in Fiscella et al's study (1997) supported IMGs' formal attitude towards local patients. "Fear of patients' bias" was identified as a major factor in forming IMGs approach to US patients in Fiscella et al. (1997).

The current study provided evidence that some of the IMGs believed that local patients preferred formal relationships with their physicians and they seemed satisfied with this

idea. Some of the IMGs could be genuinely satisfied with formal relationships with their local patients, while others preferred it as a defense mechanism to avoid being exposed to negative attitudes from their patients. However, it was also found that some of the patients in this study found themselves having to, rather than wanting to have this kind of relationship with their IMGs, as they assumed that the cultural and linguistic gap would hinder the development of a deeper relationship.

Having the perspective of both IMGs and patients, in this regard, allowed better understanding of the fact that IMGs may avoid trying to change their relationship with their local patients because they believed that patients preferred it. Coming from different cultures may have contributed to IMGs misinterpreting patients' needs and preferences. Additionally, as a result of the formal nature of the relationship, as well as a possible language barrier, it seemed that IMGs could not ask their patients overtly about their preferences. Thus, poor-quality communication could be one of the explanations for the previously researched low satisfaction rate among Saudi patients with the quality of care at the interpersonal level (AL-Ahmadi and Martin, 2005).

7.2.3.1 The effect of prejudice on IMGs' motivation to provide quality care

Adding to the direct influence in the quality of care provision, prejudice raises ethical issues and has an indirect effect on the quality of care by impacting on IMGs' psychological and physical health (R. Williams and Williams-Morris, 2000; Williams *et al.*, 2003). It has been shown that psychological and emotional well-being and health status can be adversely affected due to experiencing discriminatory behaviour (R. Williams and Williams-Morris, 2000; Williams *et al.*, 2003). The IMGs in the current study discussed experiences describing their exposure to discriminatory attitudes from

their patients. Additionally, they explained their exposure to hurtful words in some cases. Williams and Williams-Morris (2000) in their review of North American research, which looked at ways in which racism affects mental health, presented evidence that confirmed a significant positive association between self-reports of discrimination, due to race or cultural background, and psychological distress and depressive symptoms. The psychological and health effects of being exposed to discrimination may influence the work environment and hinder IMGs' motivations and ability to provide quality care to local patients.

Furthermore, due to patients' negative attitudes, IMGs may be concerned about dealing with prejudice and may therefore prioritise job security over providing appropriate care if they fear that giving a specific treatment or advice might lead to complaints by patients.

7.2.3.2 IMGs' prejudice towards local patients

Previous research has found that patients' demographic and socioeconomic characteristics affect physicians' perceptions of them, which can also affect the quality of care provision (Van Ryn and Burke, 2000). The current study supported this finding and additionally, it confirmed its existence in the cross-cultural medical encounter where physicians are IMGs caring for local patients. The effect of prejudice on the part of IMGs was exemplified by some IMGs not making an effort to appropriately advise patients as they held a stereotypical view towards them, assuming they were not health-conscious and that they would not listen to their advice. This attitude may have a negative effect on the quality of care provided by IMG's in terms of these physicians missing opportunities to educate patients who are willing to change to improve their own health. Additionally, it may affect patients' satisfaction and views on care provision.

Although most of the IMGs interviewed in this study showed aversion to patients' prejudicial attitudes, they denied that their experiences affected the care they provided to local patients. This was inconsistent with the views of the IMGs in Fiscella et al's study (1997), where the IMGs confirmed that patients' negative attitudes towards them affected their emotions and hence their ability to provide high quality care. The IMGs' refusal to accept the effect of prejudice on their motivation to provide quality care could be their actual perception. However, it could equally be an example of social or professional desirability bias in their responses, as they may not wish to reveal information that may reflect their failure to deliver the best quality health care. This was implied in some of the IMGs' responses, which reflected their view of the negative effects of physician-patient cultural discordance, as some IMGs were identified who were inflexible in their advising strategy as well as being resigned to their perception that patients would not follow their advice, and who therefore did not make a greater effort to advise patients. Their perception of local patients' prejudiced views could also be the reason behind their inflexible approach to advising these patients.

The situation of cross-cultural communication in SA is complicated; as it appeared that improving patient health outcomes is sometimes inconsistent with achieving patient satisfaction, while as noted earlier (in 3.2.1), both are components of quality health care. This relates to the finding from one IMG who felt that "patient-centred care" might not be consistent with the best care provision because it necessitated a focus on the patient's concerns rather than the physician's priorities. Thus, the assumption that good care includes a patient-centred approach could be seen as culturally determined and could therefore be challenged in a more paternalistic medical culture.

All the above factors related to prejudice have a significant influence on IMGs' ability and motivation to provide optimum care. Furthermore, these factors may greatly contribute to the high IMG turnover rate (see 1.5.2) that is recognized in SA as one of the challenges affecting the stability of its health care system (WHO, 2006; Bozionelos, 2009).

7.2.4 Strategies to overcome language and cultural barriers

The current unique situation where IMGs are not required to speak the same local language as their patients, and hence may lack both linguistic and cultural understanding, has made both physicians and patients creative in developing strategies to facilitate communication.

The professional participants in the current study developed their own strategies to improve the communication of lifestyle advice to patients with T2DM and enhance rapport. However, despite their efforts in this regard, some patients criticised their communication skills and felt that these adversely affected their care.

7.2.4.1 Non-verbal communication

The IMGs in Jain and Krieger (2011), who investigated the communication strategies used by IMGs in intercultural medical encounters, struggled to achieve basic communication, despite speaking the same language as their patients. Additionally, on another level, they used strategies to develop rapport with their patients such as repeating information and maintaining conscious eye contact. This was backed up by the findings of the current study, when patients and mostly non-Arabic speaking IMGs used facial

expressions and hand gestures to facilitate basic communication. Therefore, developing rapport with patients was more challenging for them than for other IMGs who shared a common language with their patients.

7.2.4.2 Written information

The findings showed that the IMGs, especially non-Arabic speakers, depend on written information, such as brochures and booklets, to deliver information and advice. This indicates that IMGs are using all possible resources to ease the process of conveying important health information to local patients.

The Centre for Health Information Quality in England identified verbally communicating information, which is in the form of written materials, for patients as a key attribute to ensure understanding of the written information to patients. Some IMGs however, were not familiar with the information and advice given, as it was written in Arabic. These IMGs depended on the images displayed in the booklets to familiarise themselves with the contents. However, it should be noted that some images in the brochures are not directly related to the written information and are taken from Western culture, which does not reflect the SA context. For example, a picture of young people cycling on the street is used to illustrate physical activity. Furthermore, this may provide inappropriate information to traditional, illiterate patients, as the pictures they see in the booklets may give them the impression that following the presented lifestyle advice is challenging, as the images involved do not take local cultural norms into account. The IMGs who were not familiar with the contents of the booklets they handed to their local patients may not be able to properly follow up with related advice to their patients and therefore are less

able to persuade patients to change their lifestyle and control their condition, which eventually affects the quality of patient care.

7.2.4.3 Social conversations

This study found that, from the IMGs' perspective, informal conversation could be a strategy to build rapport with local patients. Some IMGs positively used the cultural differences between them and their patients to open conversations and gain their trust. Jain and Krieger (2011), who explored communication strategies used by IMGs in intercultural medical encounters in the US, also presented similar findings.

IMGs in a previous study (Dorgan *et al.*, 2009) noted that they would eventually learn to deliver culturally appropriate care and to communicate properly with local patients; nonetheless, some IMGs in the current study described how they struggled to communicate with local patients, regardless of the duration of experience in SA.

7.2.5 Support system

In situations where they were exposed to prejudice from their patients, some IMGs felt that they were left in a vulnerable position where they did not want to, or could not confront patients about their feelings and did not know to whom they can express their feelings and find solutions for this issue. This indicates an inadequate support system for IMGs. Due to the prejudice they felt towards them and the discrimination they experienced, some IMGs hesitated to inform the PHCCs' managers and supervisors, who are responsible both for issues occurring in the PHCCs and for communication between physicians and higher authorities. The IMGs believed that these managers belong to the

local culture and hence may hold the same views as their patients. Most research on IMG support has focused on training and educational support and IMG and staff relations to one another (Cole-Kelly, 1993; Hall *et al.*, 2004; Pilotto *et al.*, 2007; McGrath *et al.*, 2009). No previous research on moral and emotional support related to issues and conflicts at the interpersonal level between IMGs and patients was identified to compare this finding with. Nonetheless, it seems likely that IMGs need to work in a supportive environment to be able to overcome the obstacles they face in delivering care to patients. In common with a previous study by McGrath et al. (2009), which involved IMGs from China, Yugoslavia, the Philippines and Sri Lanka and explored their experience before, during, and after their involvement in the Australian healthcare system, IMGs in the current study recommended that those with experience of working in the local country are the best people to provide advice, information and support.

Al-Ahmadi and Martin (2005), in their review on the quality of primary health care services in SA, found low patient satisfaction with regards to the quality of interpersonal aspects of care for reasons related to language and culture. This finding was based on a review of 31 studies in SA from 1985 to 2004, which varied in scope and methodology. The current exploratory study supported the finding that linguistic and cultural differences between IMGs and patients are major reasons for poor interpersonal communication. This study provides detailed exploration of the issue by identifying some of the elements in the language and culture that affect the quality of care at the interpersonal level, which include the existence of prejudice in the medical encounter.

Identifying the exact elements that contribute to reducing the quality of health care may help in appropriately directing financial and planning efforts to improve it.

All the studies found in Al-Ahmadi and Martin (2005), exclusively considered patients' views or depended on medical reports to evaluate quality of care. The current study provides a detailed exploration of the issue for current medical cross-cultural care at the interpersonal level in SA based on the views of both IMGs and patients with diabetes.

7.2.6 Summary of the main findings

In general, physician-patient relationships are influenced by cross-cultural medical encounters and have significant consequences for their health care experiences. As the current study shows, not sharing the same cultural background may imbalance the relationship between patients and physicians where patients may impose their opinions on IMGs. This kind of relationship potentially influences IMGs' willingness to provide lifestyle advice and their ability to provide specific treatment that is thought to be more effective by the IMG. Additionally, different expectations in relation to patients' preferences regarding care may affect the patient-physician relationship, especially when IMGs' strategies in terms of how to approach Saudi patients do not change, as they believe that their current approach is preferred by patients, for example, maintaining formal relationships. Furthermore, miscommunication or lack of communication as a result of language and cultural discordance influence patients' safety and satisfaction with care, which lead to patients not trusting the IMGs, who are the primary care providers in SA. On top of the previously noted interpersonal communication challenges, the IMGs in SA are operating in an environment that may not place adequate emphasis on supporting them. They arrive in SA for the first time without being introduced to the language or

culture and may be left to struggle alone in situations where patients' health could be jeopardized. For example, not understanding a patient's complaint could result in mistreatment, additionally not being familiar with the local use of some herbs, which could cause hypoglycemia, may make IMGs less thoughtful about their advice regarding herbal use. Not supporting IMGs to take appropriate care of local patients and build good relationships with patients may make them less confident in their ability to deal with these patients and may allow the effect of prejudice to influence the care they provide.

7.3. Strengths and limitations of the study

This section highlights some of the strengths and limitations of the current study including methodological and cultural challenges.

7.3.1 Strengths of the study

This exploratory study provides a unique contribution to the cultural competency literature and evidence base by being the first to explore IMGs' experiences in providing care to local patients in SA. It looks at cultural competence from a different angle where physicians are IMGs who are expected to provide care to local patients. The findings of this research have provided rich qualitative data that helps to develop our knowledge of cultural competence among IMGs, which has a direct effect on the quality of care provision.

The current study is unique in that it raised a sensitive topic - the existence of prejudice in medical interaction - and provided an opportunity to explore the underlying reasons for this, IMGs' feelings about it and its consequences for the quality of health care.

Review papers remain the main source of data in most previous papers published in SA in relation to cultural competence. This is the first study carried out in SA to use in-depth qualitative analysis to explore the relationship between IMGs and their patients from both perspectives.

Quality of care related literature in SA is overwhelmingly drawn from the patients' perspective and this study addresses this gap by recruiting IMGs as well. Therefore, a further strength of this study has been the fact that IMGs' voices were represented when they have been previously ignored in quality of care related research.

Telephone interviews helped to include IMGs who were not willing to be interviewed at the health care premises. Although detecting facial expressions, building rapport and having a comfortable setting to speak freely with the interviewer are easier to establish in fact-to-face interviews, the researcher was still able to detect pauses and hesitations. Furthermore, one IMG obviously felt more comfortable when interviewed by phone as he probably thought that the researcher would be less judgmental over his discourse compared to face-to-face interviews. Telephone interviews were completed without any interruption as they were carried out away from health care premises.

7.3.2 Limitations

The findings have been shaped based on Saudi culture, making it difficult to generalize in terms of other cultures. For example, patients' prejudicial views on IMGs, in SA, were developed based on the situation of expatriate workers who mostly occupy manual jobs. Nonetheless, it is possible to theoretically argue that the results of the current study could be applied to the same or similar cultures such as those in the Arab Gulf Cooperation

Countries, which include Kuwait, the United Arab Emirates, Qatar and Oman, because these countries have a similar healthcare system, with a high proportion of care being provided by IMGs to local patients.

7.3.2.1 Methodological challenges

Maximum diversity was achieved with regards to IMGs' gender, spoken language (Arabic or non-Arabic) and years of experience. Male IMGs were slightly over-represented, as they were more willing to be interviewed.

In order to obtain a better understanding of the issues under investigation, the researcher was interested in including the views of extreme cases. However, the views of "hard to reach" patients, who refrained from seeing their IMGs, were difficult to ascertain, as physicians found it difficult to identify these patients among all the patients registered in the PHCC, and were not cooperative when it came to recruiting them. However, this was compensated to some extent by interviewing patients who were specifically identified by the IMGs as "non-compliant" patients.

The vignette style of interviews is known to facilitate discussion in this type of work, as it uncovers details of participants' experiences and their views on each other. In some cases during the current study, participants responded at first to the vignette style but with the progress of the interviews, they felt more comfortable providing direct responses concerning their own experiences. On the other hand, most participants found it easier to relate to their own experiences from the beginning of the interview. Thus it was decided during the data collection phase to use more direct questions relating to participants' experiences.

7.3.2.2 Cultural challenges

The study involved some cultural challenges. For example, being a female researcher interviewing male participants in a conservative culture such as SA, could have discouraged male patients from speaking freely and comfortably. For example, in accordance with cultural norms, Saudi male patients avoided eye contact with the researcher and sometimes preferred to provide concise responses. However, to overcome this limitation, the researcher used appropriate probing questions, started general conversations and referred to the patients using the names they preferred such as "uncle.X" to develop rapport with them. Furthermore, to ease communication and gain the male participants' respect, the researcher wore a "Niqab" that is a face cover, which only reveals the eyes, when interviewing male participants, to avoid negative views, as in Saudi culture people tend to view women who show their faces critically. The researcher wore a "Abaya", which is a black, wide traditional clothing women wear when they appear in public in SA, rather than a white lab coat which female professionals are allowed to wear at work places, to give patients a sense of belonging and help them to easily share their perceptions.

Participants' views on the study, as the researcher would be sharing the findings in the UK, may have limited the number of patient participants. On occasion patients were reluctant to reveal their responses, because of their concerns that a critical view about the quality of care would be shared with the Western world. Thus, they were protective about the reputation of the Saudi health care system and quality of care. For example, one patient who explicitly expressed his negative view about sharing information with "people" from the UK followed each of the undeniable challenges in the cross-cultural

medical encounter in SA, such as language, by confirming its existence in the Western world. In contrast, the IMGs were happy to share their views, as they believed in the constructive purpose of the research and, according to them, it was the first time someone was paying attention to their experiences. A small number were hesitant and apologetic about revealing their views as the researcher belonged to their patients' culture.

7.4 Implications for policy and practice

Findings from this exploratory study suggest a number of ways to improve the quality of care provided by IMGs to patients in SA, including better patient education as well as better training and support for IMGs.

7.4.1 Dissemination strategy

The proposed dissemination strategy for this research is as follows:-

- A series of lectures to raise awareness of the findings of the current study, particularly concerning the importance of empowering IMGs and educating patients. It would be useful to conduct the lectures at the Department of Family Medicine at the KKUH in order to gain professionals' feedback and the chairman's support. Inviting the Department of Quality Management; and the Deanship of Community Service and Continuing Education at the KKUH to attend these lectures could be important as a strategy to involve them in decision making in regards to resources for training, support and education materials.

- Workshops to design and organize training programmes for IMGs using the findings from the current study, IMGs' suggestions and the literature on cultural competence training will be organized initially at the department level with the help of the

Department of Quality Management at the KKUH. IMGs will be encouraged to be involved in designing the training programmes including suggesting the best time and place to conduct them as well as planning patient education materials. These workshops could additionally include discussions in regards to best persons to conduct cultural competence training programmes. The Deanship of Community Service and Continuing Education will be responsible for providing and distributing information and materials to patients. Distributing booklets and using patient education screens in the waiting areas would help to educate patients about the IMGs' major role in delivering health care. Implementing these training and education programmes at the hospital level including all the departments might follow.

- The Saudi MOH is keen to improve its health services, striving to get its resources utilized properly. It is open to considering research findings and funding research to achieve this purpose. Highlighting the issues raised in the current study, which can be considered as the key to high quality care at the interpersonal level, is an important element to feed into the MOH current strategy to improve the quality of healthcare, in general, and primary health care, in particular. Findings of the current study will be presented at national conferences concerning quality assurance in health care and patient-physician communication, which are organized by the MOH via the SCHS. Findings will also be submitted for publication to national academic journals as a strategy to share them with the authorized personnel at the Saudi MOH.

- After testing the implementation of training IMGs to be culturally competent, and educating patients on the patient-physician relationships and quality of care at the KKUH, results could then be shared with the MOH for further reinforcement. This

could be facilitated by a team from the KKUH, including the researcher, who could approach the authorized personnel at the MOH to share the findings and gain funding.

- Meetings involving the General Administration of Quality and Patient Safety, the Department of Medical Research and Medical Education Department at the MOH could be conducted to plan how, and by whom, these training programmes would be implemented; and which educational materials would best be dispensed to IMGs and patients at the level of PHCCs. Piloting the appropriateness and effectiveness of the training programmes and patients' education on a number of PHCCs is an important step in ensuring the success of these programmes before national dissemination.

- Funding for training and supporting IMGs and educating patients could be sought from the KKUH, at the hospital level; from the Saudi MOH; or from King Abdulaziz City for Science and Technology (a governmental institution that is administratively responsible for reporting to the Prime Minister and aims to support projects involving policy making, at the national level).

- It is equally relevant to disseminate the findings internationally through academic journals emphasizing the importance of addressing patients' attitudes toward IMGs, in parallel to IMGs cultural competence training, as a strategy to improve the quality of care. Journals concerning quality in health care, transcultural health and medical education could be appropriately target journals.

7.4.2 Patient education and information

Patients could be made more aware of the significant role IMGs play in achieving the MOH's goal of delivering accessible high quality health care to all people. Educating patients, through media and high-level personnel, such as PHCCs' managers, Saudi

physicians and the health minister, or through distributing booklets about the IMGs' major role in the MOH's strategy for delivering a comprehensive and accessible health care for the Saudi population is needed. This may encourage patients to trust IMGs as valuable professional members of the PHCC team and have more confidence in their abilities.

The issue of improving the brochures and booklets handed by IMGs to patients has been raised in this study. More culturally appropriate written materials to help facilitate communication and understanding of the contents is required. Additionally, the MOH could introduce all IMGs to, and involve them in the development of, appropriate brochures and booklets.

7.4.3 IMG training

As with other developed countries, non-Arabic speaking IMGs could go through an Arabic language assessment before they are allowed to work in SA. Alternatively, they could be encouraged to attend language classes in order to facilitate a higher standard level of interaction between them and their patients. As Saudi people speak different dialects, it is not realistic to teach IMGs different dialects; however, teaching traditional Arabic could be more practical, as it is understandable to most Saudi people. Alternatively, interpreting services could be made available to all IMGs who do not speak Arabic as a mother tongue.

For IMGs to be able to meet Saudi patients' needs and expectations and learn enough about the culture to deliver appropriate care, the MOH could facilitate supportive community integration for IMGs. This could start from the local mosque or the local PHCC, where IMGs listen to patients' needs. Integrating with local people could be a

practical possibility, as each PHCC serves a defined community and could assist in developing an informal relationship between physicians and patients, enabling IMGs to directly learn about the culture, and enabling patients to get to know their IMGs on a more personal level. This may eventually improve both IMGs' confidence in providing culturally sensitive advice and the general relationship between IMGs and patients.

Empowering newly-arrived IMGs by introducing them to orientation and training programmes focusing on Saudi culture, as well as patients' needs and expectations, and delivering culturally appropriate advice and communication skills, are fundamental to improve the quality of care provided to local patients. Mentoring system where long standing or Arabic speaking IMGs partner up with new/non-Arabic speaking IMGs to support them informally and provide advice is recommended.

Patients' trust in IMGs may be increased if they become aware of these training programmes as this kind of initiative may reduce negative, preconceived ideas about IMGs' knowledge and capability in terms of providing culturally appropriate care.

7.4.4 Support structure

A line of communication should be opened to all IMGs in which they can share complaints without feeling insecure about their work or being judged by others. This would make IMGs less frustrated about confronting patients and focus more on providing care in a healthy environment. A neutral person who is not responsible for evaluating the IMGs' work could be the right person to receive their complaints and support them in regards to the right way to react to prejudicial attitude from patients. IMGs and all health professionals could benefit from more training on the most effective ways to deal with difficult patients.

Furthermore, training PHCC managers and supervisors to support IMGs and deal appropriately with cases of prejudice is also needed.

Less emphasis by PHCCs' administrations should be given to the duration of the medical consultation, especially non-Arabic speaking IMGs with less experience. Increasing appointment times, or reducing the number of patients per IMG could achieve this.

7.5 Future research

This exploratory study has highlighted a number of ways in which understanding in this field might benefit from further research building on this study's findings.

Firstly, this study has created an opportunity for potential intervention studies with regards to patients' education, patient information and IMG training. Secondly, enhancing health care efficiency through appropriately directing efforts to empower IMGs could include a research focus on IMGs' practice needs. Considering IMGs voices in developing empowering programmes is essential.

Thirdly, as each culture has its own social issues, with their own history and justifications, more research could investigate ways of changing patients' attitudes towards IMGs that work better for this specific culture. To overcome cultural challenges, future research could involve researchers of both genders.

Lastly, the issue of prejudice, which was raised in this study as a barrier to quality care, could occur at institutions other than health institutions and affect the quality of their services. Therefore, qualitative research, in general, and concerning prejudice, in particular, should be specifically considered in evaluating the quality of any service that requires interpersonal communication and is provided by international workers in SA.

7.6 Conclusion

This study has explored communication between IMGs and their local patients, using T2DM as an example of a chronic condition, which requires culturally sensitive advice.

The study has provided evidence of imbalances in the IMG-patient relationship, as well as the reasons for and consequences of this kind of relationship, which include prejudice and can be described as formal, on quality care.

Collecting data from both patients and IMGs provided good evidence that mismatches in expectations and understanding, as well as prejudice, exists on both sides of the relationship. This challenges the idea that cultural competency is an issue to be addressed solely by providing training and support for healthcare staff and highlights the fact that it may be worthwhile considering that patients can also contribute to improving cross-cultural interactions. Tackling prejudice is part of this as it has been identified that prejudice on both sides is potentially adversely affecting care.

The study has demonstrated that, regardless of the IMGs' self-adopted strategies to improve the communication of lifestyle advice to patients with chronic conditions such as T2DM, the existence of prejudice amongst local patients towards IMGs does hamper effective communication.

Because of their different cultures and lack of appropriate communication, IMGs may misunderstand local patients' preferences and needs and interact with local patients according to what they think is best for them. This may contribute to less patient satisfaction with the health care provided by IMGs.

Informing the Saudi MOH's efforts to improve the IMG-patient communication, empowering IMGs and addressing their needs, as well as educating patients, is essential in order to enhance health care efficiency in SA.

IMGs' struggles to provide high quality, culturally appropriate care, regardless of their years of experiences, indicates that, while they are theoretically expected to develop the necessary skills to be culturally competent, there are some practical barriers that may hinder this progress. These include the existence of prejudice in the IMG-patient relationship, the lack of reliable sources of information about culture and language and of cultural competence training programmes, as well as the lack of support from higher authorities. All these challenges, in addition to not finding the appropriate guidance to overcome these challenges, contribute to IMGs frustration and inability to move forward in their quest to deliver quality health care services.

In essence, not understanding patients' language and misunderstanding their needs because of their different cultural background are recognizable issues in the medical cross-cultural encounter. The present study identified language and cultural discordance as critical factors in the IMG-patient relationship that influence care provision.

In summary, this study has identified some of the key reasons why, and how, the quality of relationships and communication between IMGs and patients can adversely affect patient care in T2DM, and more generally, in chronic health conditions. The findings suggest that an increased focus on both appropriate training and support for IMGs; and on improving patients' understanding of the role and training of IMGs, could significantly improve the quality of care.

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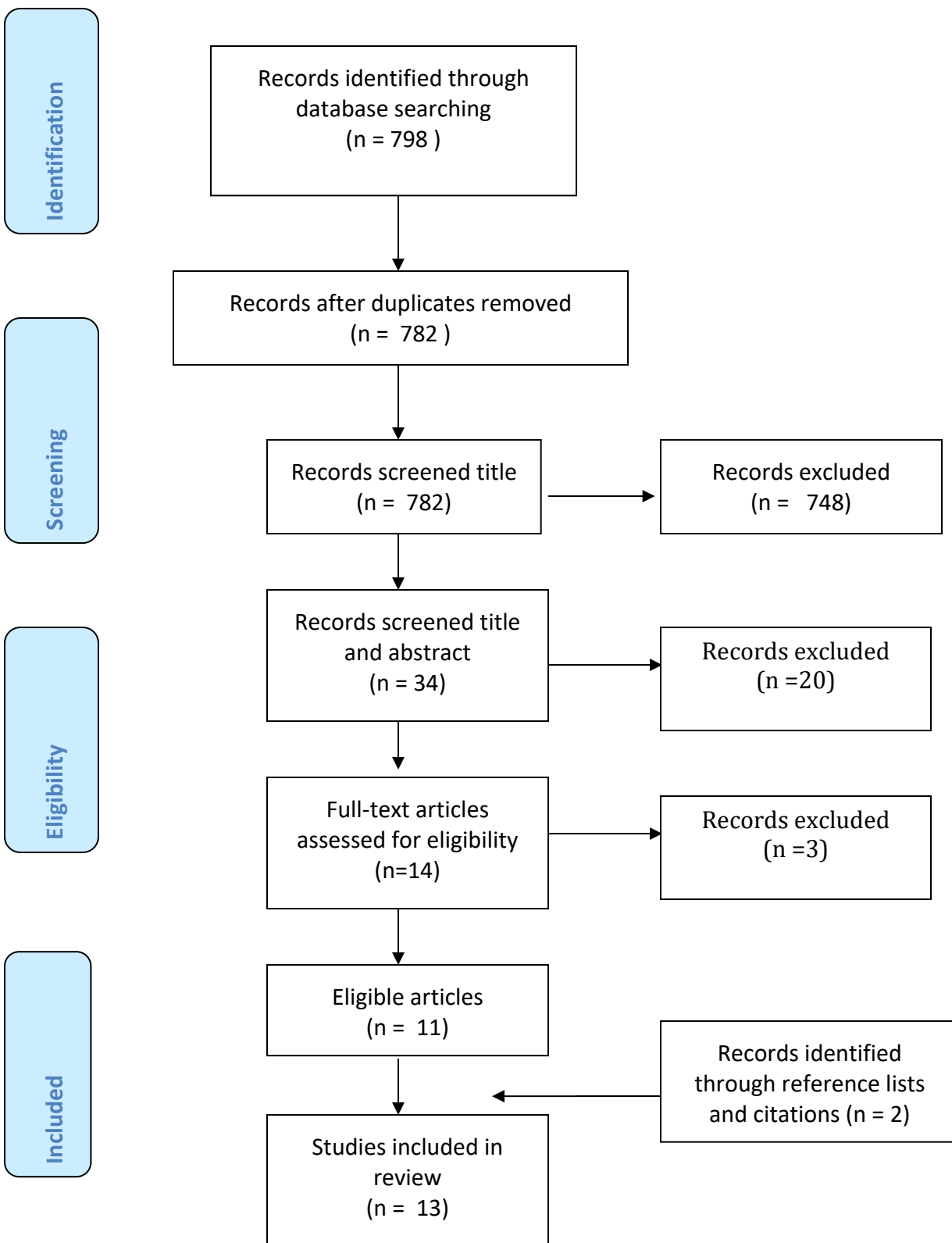Zeighami, B., Zeighami, E., Mehrabanpour, J., Javidian, I. & Ronaghy, H. (1978) Physician importation--a solution to developing countries' rural health care problems? *American Journal of Public Health,* **68** (8)**,** 739-742.

Appendices

Appendix 1 Prisma Chart: Effectiveness of cultural competence interventions
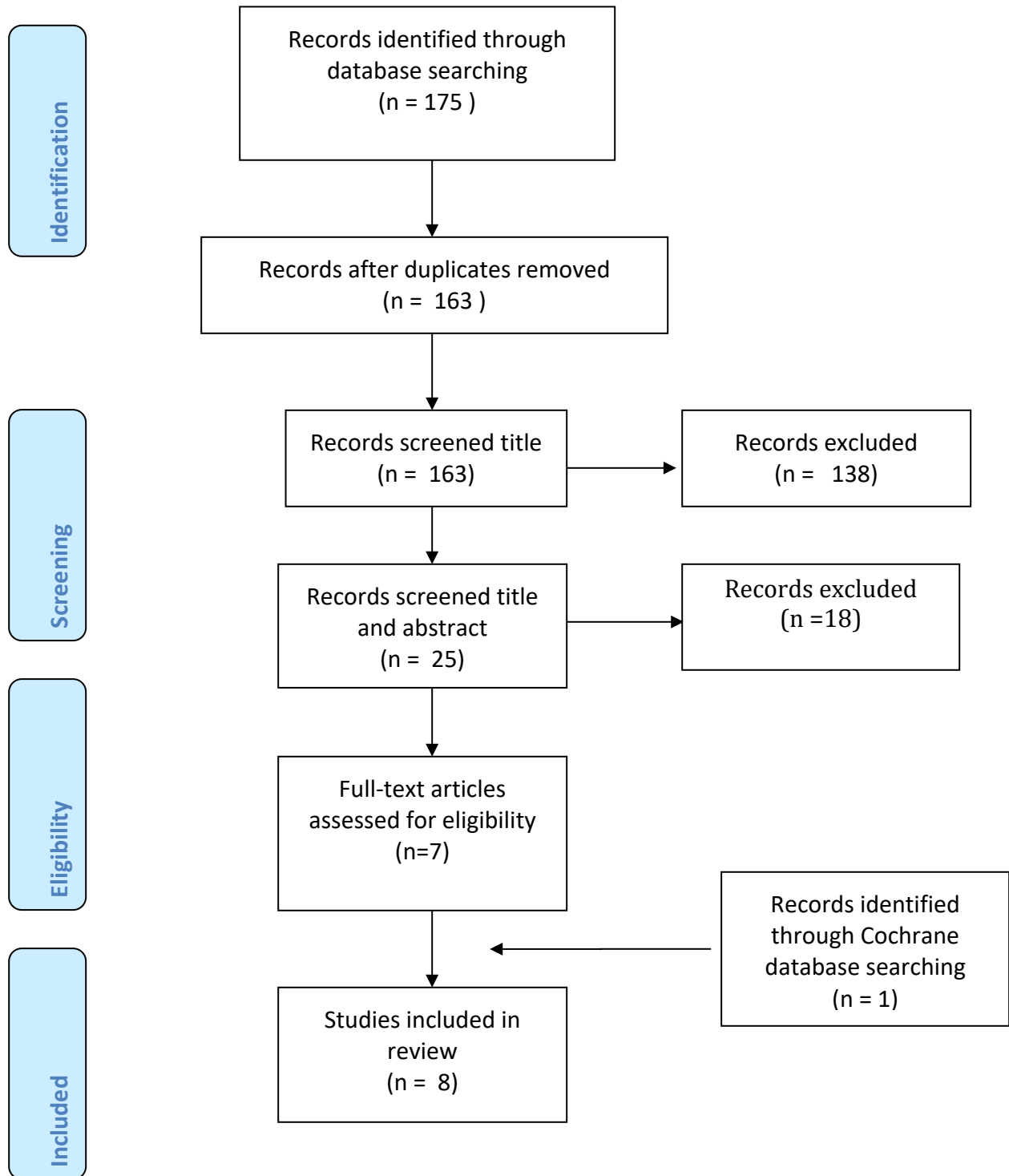
Appendix 2 Prisma Chart: Cultural similarity and workforce diversity

Appendix 3 ScHARR Ethics Approval

Cheryl Oliver
Ethics Committee Administrator

Regent Court
30 Regent Street
Sheffield S1 4DA
Telephone: +44 (0) 114 2220871
Fax: +44 (0) 114 272 4095 (non confidential)
Email: c.a.oliver@sheffield.ac.uk

Our ref: 0552/CAO

16 May 2012

Noura Abouammoh
ScHARR

Dear Noura

Experiences of expatriate primary care physicians in caring for type 2 diabetes patients in Saudi Arabia

Thank you for submitting the above research project for approval by the ScHARR Research Ethics Committee. On behalf of the University Chair of Ethics who reviewed your project, I am pleased to inform you that on 16 May 2012 the project was approved on ethics grounds, on the basis that you will adhere to the documents that you submitted for ethics review.

The research must be conducted within the requirements of the hosting/employing organisation or the organisation where the research is being undertaken.

If during the course of the project you need to deviate significantly from the documents you submitted for review, please inform me since written approval will be required. Please also inform me should you decide to terminate the project prematurely.

Yours sincerely

**Cheryl Oliver
Ethics Committee Administrator**

Appendix 4 MOH Institutional Review Board Approval

بسم الله الرحمن الرحيم

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للبحوث والدراسات

الــرقــم: ٤٨٢/١٣/٢ قيد
التــاريــخ: ٠٣ / ٠١ / ١٤٣٤هـ ٩٣٤ صباحا
المشفوعات: المرفقات: ٤ لفة
275-1-482-53-2

الموضوع: تسهيل مهمة طالبة الدكتوراة/ نورا أبوعمه

سعادة / مدير عام الشؤون الصحية بالرياض   المحترم

السلام عليكم ورحمة الله وبركاته،،،،

إشارة إلى خطاب سعادتكم رقم ٦٥٢٣٢ وتاريخ ١٤٣٣/٨/١٩هـ (مرفق صورة) بخصوص موضوع دراسة الطالبة / نورا بنت عبدالرحمن أبوعمه ، لدراسة مرحلة الدكتوراة في تخصص الصحة العامة ، رقم السجل المدني (١٠٠٤٩٣٠٩٧٨) ، والرقم الأكاديمي (R٩٩٢) وعنوان الرسالة :

"خبرات أطباء الرعاية الصحية الأولية المغتربين في العناية بمرضى السكري من النوع الثاني في مدينة الرياض، المملكة العربية السعودية: أرآء الأطباء والمرضى"

"Experiences of Expatriate Primary Health Care Physicians in Caring for Type II Diabetes Patients in Riyadh city, Saudi Arabia: Perspective of Physicians and Patients"

نحيطكم علماً بأن المذكورة قد إستوفت كافة المستندات المطلوبة وتمت مراجعتها من قبل اللجان المعنية ، وتمت الموافقة على تسهيل مهمة إجراء هذا البحث.

وحيث أن المذكورة عاليه ستنفذ دراستها فى مراكز الرعاية الصحية بمنطقة الرياض.

نأمل التفضل بالإطلاع والإيعاز لمن يلزم بتسهيل مهمتها لجمع البيانات اللازمة بما يضمن أن لا يكون هناك أي تأثير على خدمة المراجعين والمرضى خلال قيامها بمهام بحثها، مع العلم بأن وزارة الصحة لا تتحمل أية أعباء مالية أو إدارية فى البحث.

ولكم أطيب تحياتـــي ،،،

مدير عام
الإدارة العامة للبحوث والدراسات

د. مازن محمود حسنين

هاتف: +٩٦٦١٤٧٣٥٠٣٨   فاكس: +٩٦٦١٤٧٣٥٠٣٩   ص.ب الرياض: ١١١٧٦   الرمز البريدي: ٢٧٧٥
e-mail: research@moh.gov.sa

242

Appendix 5 NIH Course Result

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **NOURA ABOUAMMOH** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 11/06/2012

Certification Number: 1043903
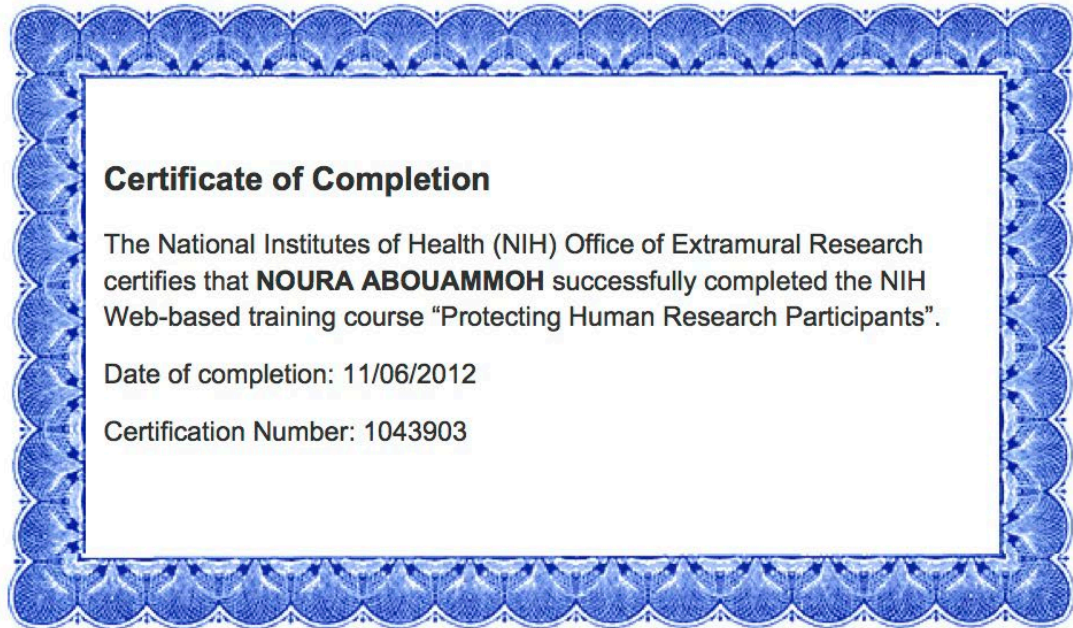
Appendix 6 KKUH Approval

Kingdom of Saudi Arabia
Ministry of Higher Education
King Saud University
College of Medicine
& King Khalid University Hospital

المملكة العربية السعودية
وزارة التعليم العالي
جَامَعَة المَلِكَ سُعود
كليـــة الطــب
ومستشفى الملك خالد الجامعي

Date February 27, 2013 : التاريخ   No.: .... : الرقم

To Whom It May Concern

I would like to inform you that **Dr. Noura A. Abouammoh** has got approval support of this department to conduct her study entitled "Experiences of Expatriate Primary Health Care Physicians in Caring for Type 2 Diabetes Patients in Saudi Arabia: Perspectives of Physicians and Patients" in the Department of Family and Community Medicine, King Khalid University Hospital. The nature of this research study does not harm participants and does not involve risks in the light of the potential career benefits to be derived there from.

Dr. AbdulAziz Bin Saeed
Chairman
Department of Family and Community Medicine
College of Medicine, King Saud University
Riyadh, Kingdom of Saudi Arabia

Appendix 7 Information Sheet for Physicians (focus group)

Research title: Experiences of Expatriate Primary Health Care Physicians in Caring for Type 2 Diabetes Patients in Saudi Arabia: Perspectives of Physicians and Patients

You are invited to take part in a research study exploring the views of expatriate primary health care physicians about the provision of care to people with type 2 diabetes in Riyadh, Saudi Arabia. Please take time to read the following information and feel free to contact me for any further clarification before you decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

The purpose of this study is to explore expatriate physicians' experiences and views in regarding to interaction with type 2 diabetes patients in Saudi Arabia. The study is being conducted in two phases. Phase 1 will collect information on physicians' experiences in interaction with Saudi patients with type 2 diabetes. In Phase 2, interviews will be held with type 2 diabetes patients to explore their side of the interaction experience.

Why have I been chosen?

You have been chosen because you are an expatriate primary health care physician at the King Khalid University Hospital working with diabetes patients.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form.

Whether you decide to take part in this study or not, will not affect your professional standing.

What are the possible benefits of taking part?

There are no immediate benefits for participating physicians; however, it is hoped that this work will give you the opportunity to contribute to the development of high quality care based on your responses, as you know that primary health care in Saudi Arabia is provided by majority expatriate physicians, who are needed to meet the demands of the health services.

What will it involve?

It will involve attendance at 1 focus group discussion to be held at the convenience of participants. The focus group will take around 1 hour and take place at the Department Seminar Room. Lunch/refreshments will be provided.

What sort of questions will I be asked?

I will be asking the group to reflect on their experiences of and views about caring for and interacting with Saudi people with type 2 diabetes. Subject to your agreement, I would like to collect some basic demographic information such as age, nationality, length of experience. Consenting participants may be invited to a subsequent interview.

Is the research confidential?

Information from the focus group will be treated confidentially. Although the discussion will not be confidential, your identity will not be revealed to anyone outside the group and will remain anonymous in analysis and reporting of the study. To enhance confidentiality, your name will be replaced by a numerical code. It will

not be possible to identify you in any reports or publications. Digital records will be protected by a password. Only I will have access to them. They will be kept until the completion of the transcribing process and then will be destroyed. No information about your identity will be linked to the transcripts.

All participants will be given a copy of the signed consent form.

Will the focus group be recorded?

Yes. With your permission, the focus group discussion will be audio-recorded, for transcription and analysis purposes. No other use will be made of the original recordings. Your identity will be removed from the transcripts and these will be kept strictly confidential.

What will happen with the results?

I will be writing this study for a PhD. Findings will be reported in a range of professional and academic journals, and used to feed into service development in the area of diabetes care.

Who is funding the research?

The research is funded by King Saud University under the supervision of the University of Sheffield, UK. Ethical approval was obtained from School of Health and Related Research, the University of Sheffield and the Saudi Ministry of Health Institutional Review Board in Saudi Arabia.

For further information contact:

Noura Abouammoh

Phone: 0504666115

Email: noura.abouammoh@shef.ac.uk

Thank you for taking the time to read this.

Appendix 8 Consent Form for Physicians

Title of the Research Project: Experiences of Expatriate Primary Health Care Physicians in Caring for Type 2 Diabetes Patients in Saudi Arabia: Perspectives of Physicians and Patients

Name of Researcher: Noura Abouammoh

Participant identification number for the project: Initials

1- I agree to take part in the above project

2- I have read the information about the above project and I understand what it is about. I have had the opportunity to ask questions about the project.

3- I understand that participation is voluntary and I am free to decide to withdraw from the study at anytime without giving any reason and without any negative consequences.

4- I understand that information shared in this interview will not be shared with the head of primary health care clinic and the department and will not affect my profession.

5- I understand that my responses will be kept anonymous and confidential and my name will not be linked to the research materials and I will not be identified or identifiable in the reports that results from the research in any way.

6- I give permission for the interview to be audio-recorded

Name of Participant: Researcher:
Date: Date:
Signature: Signature:
To be signed and dated in the presence of the participant
Original + 2 copies, one for the researcher and one for the participant
Please feel free to contact me if you have any question
Phone: 0504666115 (Saudi Arabia)   Email: noura.abouammoh@shef.ac.uk
Participant No. (   )

Appendix 9 Information Sheet for Physicians (semi-structured interviews)

Research title: Experiences of Expatriate Primary Health Care Physicians in Caring for Type 2 Diabetes Patients in Saudi Arabia: Perspectives of Physicians and Patients

You are invited to take part in a research study exploring the views of expatriate primary care physicians about the provision of care to people with type 2 diabetes in Riyadh, Saudi Arabia. Please take time to read the following information and feel free to contact me for any further clarification before you decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?
The purpose of this study is to explore expatriate physicians' experiences and views regarding interaction with type 2 diabetes patients in Saudi Arabia. The study is being conducted in two phases. Phase 1 will collect information on physicians' experiences in interaction with patients with type 2 diabetes. In Phase 2, interviews will be held with Saudi patients with type 2 diabetes to explore their side of the interaction experience.

Why have I been chosen?
You have been chosen because you are an expatriate primary health care physician who works with type 2 diabetes patients in a practice which has agreed to participate in recruiting physicians for this study.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. Whether you decide to take part in this study or not will not affect your professional standing.

What are the possible benefits of taking part?

There are no immediate benefits for participating physicians, however, it is hoped that this work will give you the opportunity to contribute to the development of high quality care based on your responses, as you know that primary health care in Saudi Arabia is provided by majority expatriate physicians, who are needed to meet the demands of the health services.

What will it involve?

It will involve participating in an interview to be held at your convenience. The interviews will take around 1 hour and take place in the practice.

What sort of questions will I be asked?

I will be asking you to reflect on your experience of and views about caring for and interacting with Saudi people with type 2 diabetes. Subject to your agreement, I would like to collect some basic demographic information such as age, nationality, and length of experience. If you consent, you may be invited to a subsequent interview.

Is the research confidential?

This research is confidential. Your identity will not be revealed to anyone and will remain anonymous in analysis and reporting of the study. Your name will be replaced by a numerical code. The name of your practice will not be recognisable and you will not be identifiable in any reports or publications. Transcripts will be typed up on my personal computer and saved on the researcher's university account in a file that will be protected by a password. Digital records will be protected by a password. Only I will have access to them. They will be kept until the completion of the transcribing process and then will be destroyed. No information about your identity will be linked to the transcripts.

All participants will be given a copy of the signed consent form.

Will the interview be recorded?

Yes. With your permission, the interview will be audio-recorded, for transcription and analysis purposes. No other use will be made of the original recordings. Your identity and the name of the practice in which you work will be removed from the transcripts and these will be kept strictly confidential.

What will happen with the results?

I will be writing this study for a PhD. Findings will be reported in a range of professional and academic journals, and used to feed into service development in the area of diabetes care.

Who is funding the research?

The research is funded by King Saud University under the supervision of the University of Sheffield, UK. Ethical approval was obtained from School of Health and Related Research, the University of Sheffield and the Saudi Ministry of Health Institutional Review Board in Saud Arabia.

For further information contact:

Dr. Noura Abouammoh

Phone: 0504666115 (Saudi Arabia)

Email: noura.abouammoh@shef.ac.uk

Thank you for taking the time to read this.

Appendix 10 Demographic Information: physician participants

The University Of Sheffield.

Name (optional):
Age:
Gender: O Male   O Female
Place of birth:
Mother tongue:
Length of time practicing in Saudi Arabia:
In a typical week, how many patients with type 2 diabetes do you see?

Participant No. ( )

Appendix 11 Topic Guide for Physicians (focus group)

- What does the term patient-centred care mean to you?

- Do you think, as an institution, you are able to provide patient-centred care? Why/why not?

- How do you describe your role in caring for Saudi patients with type 2 diabetes?

- How do you assess the needs of type 2 diabetes patients? [Any specific hospital policies?]

- Do you think there are challenges in treating Saudi patients with type 2 diabetes? Can you give me examples of these challenges?

- Do you think being an immigrant physician can affect your relationship with your patients? (Prompt: any positives?)

- Can you describe how you would discuss a treatment plan with a type 2 diabetes patient?

- How do you assess whether patients have followed your advice? (Prompts: if they don't follow advice, Why?)

- What suggestions do you have to improve your contribution in caring for type 2 diabetes patients in Saudi Arabia?

- Are there any issues that you think I haven't covered that you would like to add?

Appendix 12 Topic Guide for Physicians (semi-structured interviews)

The University Of Sheffield.

Introduction

Check preferred name (   )

Information sheet seen (   )

Sign consent form together (   )

Everything that we discuss today is confidential. The information that we collect from the interview will be made anonymous. With your permission I would like to record the interview. This will help me to focus on the important things that you say and I won't have to make any notes during our discussion. However, if you would prefer for me not to record the interview then let me know and I can take notes.

The interview will take us approximately one hour to complete.

 (The gender of the physician in the vignette will be changed when interviewing female IMGs)

Dr.Afzal is a 33 year old Indian physician. He came to work in Riyadh 3 years ago as a GP in a community clinic.

-Do you think Dr. Afzal is facing any challenges living in Saudi Arabia? (Prompt: What are the positives)?

-What do you think his experience of work would be like? (Prompt: colleagues, language, culture, social integration…)

-How can you relate this to your own experience of living and working in Saudi?

Dr. Afzal sees around 80 Saudi patients with type 2 diabetes every week. He has a nurse from Philippines.

-How should be the relationship between Dr.Afzal and his Saudi patients?

-Do you think that Dr. Afzal can build that relationship with his Saudi Patients? (Prompt: Obstacles and facilitators)

-Do you think that, because Dr. Afzal is an IMG, this may affect his relationship with his patients? How?/why not? (Prompt the issues that may arise)

-Can you describe the relationship between yourself and your Saudi diabetes patients?

Mr.Ahmed is one of Dr. Afzal's patients. He is a 55 year old Saudi male who was diagnosed with type 2 diabetes 6 years ago. Dr. Afzal sees Ahmed regularly, since he started working in the clinic.

-What do you think are the challenges that Dr. Afzal's faces in interacting Mr.Ahmed? Any facilitors? Repeated

-In what way are consultations with Saudi patients different or similar to those patients who share your background?

-In your opinion, do Saudi diabetes patients prefer to be seen by IMG or a Saudi GPs? Why?

-Do you think diabetes outcome would differ between those who are followed by IMG and with Saudi GPs?

During each consultation, Dr. Afzal checks the progress of Mr. Ahmed's management plan, asks him if he has any complaints about his condition, or any other complaints, and provides him with the appropriate advice. Mr. Ahmed usually agrees to follow his doctor's advice.

-What are the barriers and facilitators to involving Saudi diabetes patients in the consultation? (Prompt: understanding)

-How can you relate this to your own experience? [Prompts: do patients agree to follow advice? Do they actually follow advice? What steps do you take if they don't follow advice?]

-Are you satisfied with the level of care you are providing? (If no, why?)

-Do you have any suggestions to improve the contribution of international physicians, in caring for type 2 diabetes patients in Saudi?

End by asking if there is anything they want to add, or any important issues they feel were left out.

Thank you for your time.

Appendix 13 Topic Guide for Patient Interviews

The University Of Sheffield.

Introduction

Check preferred name (   )

Information sheet seen (   )

Sign consent form together (   )

Everything that we discuss today is confidential. The information that we collect from the interview will be made anonymous. With your permission I would like to record the interview. This will help me to focus on the important things that you say and I won't have to make any notes during our discussion. However, if you would prefer for me not to record the interview then let me know and I can take notes.

The interview will take us approximately one hour to complete.

(The gender of the physician and the patient in the vignette will be changed when interviewing male patients)

Aisha is a 50 year old Saudi housewife diagnosed with type 2 diabetes 4 years ago, for which she sees her Pakistani GP, Dr. Sonia, every three/six months.

-In general, how do you think the consultation between Aisha and her Pakistani doctor is going ? (Prompt: relationship and interaction)

-What does Aisha expect from her doctor?

-Do you think Dr. Sonia is able to meet Aisha's expectations? If no, why?

-Can you describe your own relationship with your doctor here in the clinic?

Dr. Sonia explained the disease to Aisha when she was diagnosed with type 2 diabetes. She gives her lifestyle advice regularly, prescribes some medication and changes the dose if necessary.

-What are the barriers and facilitators for Aisha to understand her doctor?

-What should Aisha do if she doesn't understand her doctor?

-Do you think Aisha prefers to be given the option to choose between different

management plans or just listen to what Dr.Sonia tells her? Why?

- Can the fact that Dr.Sonia is not Saudi affect Aisha's opinion about with her? How?

-Do you prefer to be seen by a Saudi or non-Saudi physician? Why?

Dr. Sonia realised that Aisha leaves the clinic without understanding her advice

-Why does Aisha keep visiting her doctor if she does not understand her?

-In your opinion, what does Aisha need from the medical consultation with her Pakistani doctor to be able to take care of her condition?

-What can Dr.Sonia do to make sure that Aisha understands her? Follow her advice?

-Do you personally understand your doctor's advice? (Prompt: obstacles and facilitators)

-Is there anything you would like to add?

Thank you for your time

Appendix 14 Interview Schedule for Follow-up Interviews

- What do you think are the differences and similarities between interaction with a
  Saudi physician and an interaction with an IMG?

- What action would you take, or recommend others take, if they experience
  prejudice from patients (Probe: talk to the patient, report to the supervisor or
  any other strategy)

- I have found from the data I collected previously that some non-Arabic speaker
  IMGs do not always re-affirm or reiterate lifestyle advice if the patient has
  previously seen by an Arabic-speaking physician. Why do you think this is?

- I have found that IMGs provide conflicting advice e.g. some of them adapt to
  the Saudi food habits by asking patients to limit their date intake while others
  prohibit their patients from having dates. In your opinion, why is this conflict
  happening? (Probe: language, awareness of strategies and patient compliance)

- What differentiates those IMGs who think up achievable strategies to improve
  lifestyles and those who feel they have no influence? (Probe: IMGs beliefs in
  their ability to influence patients' lifestyles, resilience?)

- IMGs demonstrated familiarity with cultural norms. How do you see the effect
  of their familiarity on building rapport and patient compliance? (i.e. traditional
  medicines, social etiquette, women and exercise?)

- Knowing that the SA diet is unhealthy in relation to T2DM, what strategies are adopted to advise patients on diet and exercise?

- IMGs are often giving the same advice as their Saudi counterparts, but patients are not acknowledging this, why do you think this is? (Probe: prejudice or preconceived ideas that a 'foreigner' won't understand local needs)

Thank you for your time

Appendix 15 Information Sheet for Patients (Arabic)

صحيفة المعلومات والموافقة المستنيرة للمرضى:

عنوان البحث: تجارب أطباء الصحة العامة المغتربين في العناية بمرضى السكري من النوع الثاني في المملكة العربية السعودية: أراء الأطباء والمرضى.

أنت مدعو للمشاركة في مقابلة شخصية كجزء لإتمام البحث المذكور أعلاه. سينظر البحث إلى تجاربك في التواصل مع أطباء الرعاية الأولية المغتربين. قبل اتخاذك قرار الانظمام في هذا البحث, أرجو منك فهم سبب إجراء و مضمون هذا البحث. أرجو منك عدم التردد بسؤالي في حال استصعب عليك فهم أي نقطة في هذه الصحيفة أو إذا رغبت في معرفة مزيد من المعلومات. أشكرك لقراءة الصحيفة.

ما هو الغرض من المقابلة؟

الغرض من هذه الدراسة هو الاستطلاع على تجاربك و رأيك في التواصل مع أطباء الرعاية الصحية الأولية المغتربين. نريد في هذه الدراسة تقديم الفرصة لمريض السكري من النوع الثاني للتحدث عن تجاربه و مشاركتنا بأفكاره و شعوره تجاه الرعاية المقدمة له من قِبل الأطباء المغتربين.

لماذا تم اختياري للمشاركة؟

تم اختيارك للمشاركة لأنه تم تشخيصك بداء السكري من النوع الثاني وتتابع حالتك مع طبيب مغترب.

هل تجب علي المشاركة؟

يرجع لك قرار المشاركة أو عدمها. في حال قرارك بالمشاركة سيتم إعطاؤك صحيفة المعلومات للاحتفاظ بها و سيُطلب منك قراءة والتوقيع على الموافقة المستنيرة. قرارك بالمشاركة أو عدمها لن يؤثر بأي شكل من الأشكال على الرعاية المُقدمة لك

ماذا أستفيد من مشاركتي بهذه الدراسة؟

لا يوجد هناك فوائد مباشرة في حال المشاركة بهذه الدراسة, لكننا نأمل بأن الدراسة ستوفر لك الفرصة بالمشاركة في ارتقاء نوعية الرعاية المُوفرة لك من خلال الاستماع إلى احتياجاتك في ما يخص هذا المجال

ماذا ستتضمن هذه الدراسة؟

في حال موافقتك على المشاركة سأقوم بتنظيم مقابلة معك في الوقت المناسب لك. ستستغرق المقابلة حوالي الساعة, على أكثر تقدير. ستتم المقابلة في العيادة المسجل بها.

ما هي طبيعة الأسئلة التي سوف تطرحونها؟

نود منك التفكير في تجاربك و آرائك فيما يخص الرعاية المقدمة لك من أطباء الرعاية الأولية المغتربين. بعد الخضوع لموافقتك, سيتم جمع بعض المعلومات الأساسية مثل, العمر والوظيفة

هل ستكون معلوماتي سرية؟

نعم, معلوماتك في هذه الدراسة ستكون سرية. لن يُفصح عن هويتك لأي كان وستضل شخصيتك مجهولة. سنستخدم رمز رقم للتعبير عنك عوضا عن اسمك و لن يُفصح عن أسم العيادة التي تتابع حالتك لديها. لن يُعرّف عنك باسمك بأي تقرير ينتج عن هذه الدراسة. سيتم تسجيل نص المقابلة و طباعتها و, سأحتفظ بالنسختين بجهاز حاسب في حسابي الشخصي في الجامعة في ملف محفوظ بكلمة سر لا يغرفه غيري. سيتم الحفاظ عل التسجيلات إلى أن تتم طباعتها و من ثم سيتم إتلافها. لن يوجد أي معلومات عن هويتك يمكن ربطها بالنصوص.

في حال وجود موضوع خطير و مقلق من قِبل الباحث في ما يخص الرعاية التي تتلقاها, سيتم نصحك لإحالة الموضوع للشخص المناسب في المركز الصحي و لن يتم كسر اتفاق السريّة.

سيتم إعطاء نسخة من الموافقة المستنيرة لجميع المشاركين.

هل سيتم تسجيل المقابلة الشخصية صوتيا؟

في حال الحصول على موفقتك, سيتم تسجيل المقابلة صوتيا لغرض طباعة النصوص و تحليلها فقط. هويتك سوف تلغى من النصوص المطبوعة و لن يستطيع أي شخص تتبع هوية المتحدث.

ماذا لو غيرت رأيي في الموافقة على المشاركة؟

تستطيع تغيير رأيك في أي وقت و لن يتم إضمامك في نتائج الدراسة. قرار انسحابك من الدراسة أو عدم موافقتك للمشاركة لن يؤثر على الرعاية التي تتلقاها من المركز.

كيف ستستخدم نتائج هذه الدراسة؟

سيتم استخدام النتائج كجزء من بحث درجة الدكتوراة. ستعرض النتائج على عدد من المجلات الأكاديمية المتخصصة. ستعرض على الجهات المختصة في وزارة الصحة للارتقاء بمستوى الرعاية المقدمة لمرضى السكري في المملكة العربية السعودية.

من هم مجيزوا أخلاقيات هذه الدراسة ؟

تم الحصول على موافقة لجنة أخلاقيات البحوث في جامعة شيفيلد في المملكة المتحدة ووزارة الصحة في المملكة العربية السعودية

ماالذي يجب علي فعله الآن؟

إذا رغبت بالمشاركة في المقابلة, أرجو منك التواصل مع طبيبك في المركز أو معي مباشرة عن طريق المعلومات المتوفرة أدناه. بعد الحصول على موافقتك سأتواصل معك بالطريقة التي تناسبك لتنظيم وقت للمقابلة و للإجابة على أي استفسار تود طرحه.

أرجو عدم التردد في حال وجود اي استفسار أو في حال رغبتك في التحدث عن هذه الدراسة لأحد من أفراد عائلتك أو أصدقائك.

شاكرة لكم تعاونكم

لمزيد من معلومات التواصل:

نورا عبدالرحمن أبوعمه.

هاتف: 0504666115

بريد الكتروني: Noura.abouammoh@shef.ac.uk

Appendix 16 Consent Form for Patients (Arabic)

الموافقة المستنيرة للمرضى:

عنوان البحث: تجارب أطباء الصحة العامة المغتربين في العناية بمرضى السكري من النوع الثاني في المملكة العربية السعودية: أراء الأطباء والمرضى.

اسم الباحث: نورا عبدالرحمن أبوعمه

أقر أنا الموقع أدناه على الآتي:

-الموافقة على المشاركة بالبحث المذكور أعلاه

-قرأت أواستمعت إلى المعلومات المذكورة في صحيفة المعلومات وفهمتها. كما أُعطيت لي فرصة أبداء استفساراتي عن الدراسة

-أدرك بأن المشاركة غير إجبارية و لي حق الانسحاب من الدراسة في اي وقت بدون إعطاء أي تبريرات لذلك و بدون أي عواقب سلبية

-أدرك بأن المعلومات التي سأفصح عنها لن تُشارك مع الطبيب المعالج لي وأن في حال وجود أي مشكلة في طريقة العلاج تؤثر على صحتي ستنصحني الباحثة للذهاب للشخص المناسب

-أدرك بأ المعلومات التي سأفصح عنها ستكون مجهولة المصدر و هويتي ستكون سرية و غير قابلة للتعريف و لن يربط اسمي بالنصوص الصادرة من هذا البحث

-أسمح بتسجيل المقابلة صوتيا

الباحث: نورا عبدالرحمن أبوعمه   اسم المشارك:

التاريخ: التاريخ:

التوقيع: التوقيع:

توقع و تؤرخ نسختين بحضور المشارك. نسخة للباحث و نسخة للمشارك

الرجاء عدم التردد في حال وجود أي استفسار

نورا عبدالرحمن أبوعمه

هاتف: 0504666115

بريد الكتروني Noura.abouammoh@shef.ac.uk

رقم المشارك (   )

Appendix 17 Information Sheet for Patients

Research title: Experiences of Expatriate Primary Health Care Physicians in Caring for Type 2 Diabetes Patients in Saudi Arabia: Perspectives of Physicians and Patients

You are being invited to participate in an interview, as a part of a study looking at your experiences in communicating with expatriate primary health care physicians, and how this communication might influence your decisions to take care of your health. Before you decide to be involved, it is important for you to understand why the research is being done and what it will involve. Ask me if there is anything that is not clear or if you would like more information. Thank you for reading this.

What is the purpose of the interview?

The purpose of this study is to explore your experiences and views in regard to communication with primary care expatriate doctors. We want to give people with type 2 diabetes the chance to talk about their experiences and share their thoughts and feelings about the care they have received from expatriate physicians.

Why have I been chosen?

You have been chosen because you have been diagnosed with type 2 diabetes and you are being treated by an expatriate doctor.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Whether you decide to take part in this study or not will not affect care provided to you.

What are the benefits of taking part?

There are no immediate benefits if you take part; however, it is hoped that this work will give you a chance to participate in improving the care provided to you.

What will this study involve?

If you agree to participate I will arrange an interview at a time that is convenient for you. The interview will take around an hour. This will take place in the practice you are registered in.

What sort of questions will I be asked?

We would like you to think about your experiences and views about being cared for by an expatriate doctor. Subject to your agreement, I would also like to collect some basic information such as age and occupation.

Is the research confidential?

Yes, this research is confidential. Your identity will not be revealed to anyone and will remain anonymous. I will use a numerical code instead of your name and will not reveal the name of the clinic where you are registered. You will not be identified by name in any reports arising from this study. Digital records will be protected by a password. Only I will have access to them. They will be kept until the completion of the transcribing process and then will be destroyed. No information about your identity will be linked to the transcripts.

If a serious concern is depicted by the researcher about your care, you will be advised to refer this matter to the appropriate health care worker and the researcher will not break confidentiality.

All participants will be given a copy of the signed consent form.

Will the interview be recorded?

With your permission, interviews will be audio-recorded, for transcription and analysis purposes. Your identity will be removed from the transcripts. Only I will have an access to them.

What if I change my mind?

You can change your mind at any time and you will be not included in the study. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to the results of the research?

I will be writing this study for a PhD. Findings will be reported in a range of professional and academic journals, and used to feed into service development in the area of diabetes care.

Who is funding the research?

The research is funded by King Saud University under the supervision of the University of Sheffield, UK. Ethical approval was obtained from School of Health and Related Research, Sheffield, King Khalid University Hospital and the Saudi Ministry of Health Institutional Review Board in Saudi Arabia.

What do I need to do now?

If you would like to take part in the interview, please either contact your doctor or contact me, on the contact details below. After I receive your reply I will then contact you by telephone to arrange the interview and answer any questions you may have.

You are being given this information sheet to keep and you will be given a signed copy of the consent form. Feel free to call me with any queries you may have and/or talk the study over with anyone else.

For further information contact:

Noura Abouammoh

Phone: 0504666115

Email: noura.abouammoh@shef.ac.uk

Appendix 18 Consent Form for Patients

Title of the Research Project: Experiences of Expatriate Primary Health Care Physicians in Caring for Type 2 Diabetes Patients in Saudi Arabia: Perspectives of Physicians and Patients

Name of Researcher: Noura Abouammoh

Participant identification number for the project: Initials

1-I agree to take part in the above project

2-I have read or listened to the information about the above project and I understand what it is about. I have had the opportunity to ask questions about the project.

3-I understand that participation is voluntary and I am free to decide to withdraw from the study at anytime without giving any reason without any negative consequences.

4-I understand that information shared in this interview will not be shared with health care practitioners and I will only be advised to speak with the appropriate worker if a serious health concern is depicted by the researcher.

5-I understand that my responses will be kept anonymous and confidential and my name will not be linked to the research materials and I will not be identified or identifiable in the reports that results from the research.

6- I permit to audio-record the interview.

Name of Participant: Researcher:

Date: Date:

Signature: Signature:

To be signed and dated in the presence of the participant

Original + 2 copies, one for the researcher and one for the participant

Please feel free to contact me if you have any question

Phone: 0504666115

Email: noura.abouammoh@shef.ac.uk   Participant No. (   )

Appendix 19 Demographic Information: patient participants

The University Of Sheffield.

Name (optional):
Age:
Gender: O Male   O Female
Education/Occupation:
Length since first diagnosed with type 2 diabetes:
How often do you see you physician for diabetes follow-up?
O 3 months   O 6 months   O 12 months

                                                              Participant No. ( )

Appendix 20 Deriving a Theme

Global theme: Interaction and rapport-building in cross-cultural medical encounters

Descriptive codes	Analytical themes	Organizing themes
- Trust between IMGs and patients - Rapport-building - Patients' information disclosure	1- Most of the IMGs were aware of the importance of rapport-building in improving the quality of care (one IMG disagreed) 2- Most of the IMGs believed that local physicians are better able to build rapport with patients and hence more trusted by them	Rapport building and quality of care provision
- Changing relationship-building approach - Formal/informal relationship	1- The IMGs were aware that local patients need different approach than that needed by patients in their home countries 2- The IMGs and the patients showed different relationship-building expectations 3- IMGs have different expectations regarding shared decision making than that of patients	Different expectations between IMGs and patients
- Equal - Dominant/superior - Patients control IMGs	1- Patients look inferiorly to IMGs	Patient-physician power dynamic

- IMGs seen as servants - Linking IMGs to domestic labour - Respect - IMGs' financial position	1- Some IMGs do not feel that they are respected from their patients because of their cultural backgrounds 2- One IMG thought that patients' prejudicial behaviours are accepted because they dominate in the community 3- The IMG explained their ways of handling prejudice	Prejudice in the medical interaction
- Frustration - Satisfy patients	1- According to some patients, IMGs' struggle to communicate information may force them compromise the quality of care	The influence of coping with challenges on care provision