Published in final edited form as:
Qual Health Res. 2009 June ; 19(6): 778–789. doi:10.1177/1049732309335269.

Considering Culture in Physician– Patient Communication During Colorectal Cancer Screening

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Abstract

Racial and ethnic disparities exist in both incidence and stage detection of colorectal cancer (CRC). We hypothesized that cultural practices (i.e., communication norms and expectations) influence patients' and their physicians' understanding and talk about CRC screening. We examined 44 videotaped observations of clinic visits that included a CRC screening recommendation and transcripts from semistructured interviews that doctors and patients separately completed following the visit. We found that interpersonal relationship themes such as power distance, trust, directness/indirectness, and an ability to listen, as well as personal health beliefs, emerged as affecting patients' definitions of provider–patient effective communication. In addition, we found that in discordant physician–patient interactions (when each is from a different ethnic group), physicians did not solicit or address cultural barriers to CRC screening and patients did not volunteer culture-related concerns regarding CRC screening.

Keywords

cancer; screening; communication; doctor-patient; culture

Among the cancer detection tests known to significantly reduce mortality, screening for colorectal cancer (CRC) is utilized least (U.S. Department of Health and Human Services, n.d.; Vernon, 1995; Walsh, Posner, & Perez-Stable, 1999). Rates of CRC screening are lowest among the underserved, those who are non-White or non-English-speaking, and/or those of low socioeconomic status. In fact, as is true for many cancers, CRC mortality is highest among African Americans, and rates of late-stage diagnosis are higher for African Americans, Asians, and Hispanics than for non-Hispanic Whites (Morris et al., 1999).

Unlike the Papanicolaou (Pap) test (a screening test for cervical cancer, often performed in the course of other procedures) and mammography (commonly available without a referral), CRC screening depends on both clinician referral and patient follow-up. Effective communication—the exchange of messages in which the meaning is mutually understood—between provider and patient is pivotal. When this involves a cross-cultural encounter, as is

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often the case for African American, Asian, and Latino patients, the potential for misunderstanding or ineffective communication increases (Kreps & Kunimoto, 1994; Roter & Hall, 1992). We hypothesized that cultural practices—particularly in relation to communication norms and expectations—influence patients' and their physicians' understanding and talk about CRC screening. Specifically, we set out to explore how African American, Chinese, and Latino patients view effective communication in their medical encounters that include a CRC-screening recommendation and how culture influences their definitions of effective communication. Our study is the developmental phase for future intervention research. In this article, we examine videotaped observations of physician–patient CRC screening discussions and postvisit interviews with patients in which the videotaped interaction was viewed and discussed. First, we introduce some of the cultural concepts that inform cultural practices in relation to communication norms and expectations, thus setting the foundation for the discussion of our findings. We also review relevant research in provider–patient communication to guide our analysis. Next, we discuss our methods, followed by a reporting of the themes that emerged from our analysis of the videotaped direct observations of physician–patient discussions of CRC screening and postvisit interviews with patients. Finally, in the conclusion, we address the significance and limitations of our study.

Culture and Communication

Cultural norms and expectations play important roles in communication. Three prominent cultural concepts that might influence perceptions of effective communication across different groups include power distance (i.e., the extent to which we accept unequal power relations), orientation toward time (i.e., whether we focus on the present or the future), and low- and high-context communication styles (i.e., the tendency to communicate in an explicit or implicit way; Gudykunst, 2004). Cultural groups characterized by low power distance emphasize equality, legitimate power, and interdependent relationships between superiors and subordinates (Hofstede, 2001). Therefore, a patient from this type of cultural background might expect, and be receptive to, an approach to a CRC discussion in which both the physician and patient share opinions, concerns, and beliefs. On the other hand, inequality, referent/coercive power, and dependent relationships of subordinates on superiors dominate in cultural groups that are characterized by high power distance (Hofstede, 2001). In this case, the patient would expect, and most likely accept, authoritative and "expert" recommendations from the physician. Hofstede's power distance index shows that the United States is a low power-distance culture, whereas China, Mexico, and Guatemala are high power-distance cultures. An example of the influence of high power distance on physician–patient communication is found in Smith's (1999) work in Hong Kong. Smith reported that Hong Kong patients expect their doctors to engage in doctor-centered communication of giving explanation and advice, not listening or caring. Quick healing, cost, and convenience were patients' primary concerns. Similarly, in a U.S.-based study of perceptions of cultural factors affecting medical encounters, patient submissiveness emerged as a cultural element in both Latino and White patients' accounts. Latinos tended to perceive the physician as being in control of the medical encounter. One White female patient felt her culture empowered her to challenge information given by physicians, whereas one White male patient was reluctant to challenge physicians' socially prescribed authority (Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005). An Australian study showed that Aboriginal patients often give answers that they believe are expected because it is impolite to contradict clinicians or respond negatively, given their unequal and distant relationships (Cass et al., 2002). As these studies show, cultural expectations of low and high power distance influence physician–patient communication in different settings.

Orientation toward time is another cultural concept that we considered in our study. In cultural groups characterized by future orientation, members prepare for things that might or might not happen in the future, and advance planning is part of their lifestyle. On the other hand, in cultural groups in which the present is more important than the future, members tend to deal with issues as they come, and they are less motivated by future rewards (Hall, 1983). Hall described North Americans as future oriented. Marin and Marin (1991) characterized most Hispanic cultural groups as focused on the present more than the future. African Americans were found to be more present-oriented than White Americans regarding their daily experiences with managing hypertension (Brown & Segal, 1996). Chinese, on the other hand, showed respect for tradition and their reference of the past. Tradition was negatively associated with their desire to purchase new products (Spears, Lin, & Mowen, 2001). Individual beliefs and attitudes about the future affect how risks and preventive measures such as screening tests are perceived, and thus how a CRC-screening recommendation is understood and received. Carrese and Rhodes (1995) found that Navajo patients were upset with discussions of risks associated with treatment, and perceived advance care planning (e.g., living will, durable power of attorney) as opposite to their way of thinking.

In addition to the aforementioned conceptual differences, communication styles differ among cultural groups. In low-context cultural groups, people tend to communicate in a direct and explicit fashion (most or all meaning is expressed in words), and context (e.g., relationship and environment) is not very important to them. On the other hand, people in high-context cultural groups often communicate indirectly and implicitly (more meaning might be found in what is not said). Context plays an important role in sending and receiving messages (Hall, 1983). Differences in communication styles influence physician–patient visits with regard to whether a message is communicated directly or indirectly, and whether one prefers explicit or implicit ways of speaking. These differences especially hold true in the case of conveying negative information. Gao and Ting-Toomey (1998) characterized the Chinese communication style as high-context, wherein indirectness and implicitness are preferred. Similarly, Mexico and Guatemala fall on the high-context end of the continuum (Gudykunst, 2004). European Americans, on the other hand, tend to adopt a low-context style of communication (Gudykunst, 2004). Kochman (1990) described African Americans' verbal style as expressive and emotionally animated. Carrese and Rhodes (1995) noted that the current standard of care prescribes direct and explicit discussion of negative information in physician–patient communication. However, Navajos believe that negative words can result in harm. Similarly, in a study in Northern Italy, Gordon (1990) reported that as the probability and certainty of a diagnosis of cancer increases, physician communication to a patient becomes less direct. Some Italian physicians seemed to view a malignant tumor as a taboo, and resisted acknowledging such a diagnosis directly (Gordon, 1990). Gordon's research illustrates the important role the physician's cultural background and communication practices play in physician–patient interactions, an insight particularly relevant to our study findings.

Patient and Provider Communication

Although the research on physician–patient communication spans a broad spectrum, there are several focused areas of relevance to our research question. One such area involves macro-level analyses of physician–patient communication addressing issues that concern the entire visit, and possibly several visits. An important finding from macro-level studies is that physicians tend to change little from one patient to another, and physician–patient communication is often doctor-centered (Deveugele, Derese, & De Maeseneer, 2002; Piccolo, Mazzi, Saltini, & Zimmermann, 2002). Other research has shown that individual patients have different needs with regard to how information is presented (i.e., descriptive talk vs. numeric/graphical talk; Edwards & Elwyn, 2001), what they want to discuss in the visit, and the role they want to play in decision making (Bensing, 2000). These studies provide insight into physician–patient communication in office visits.

Research on successful communication strategies is also relevant to our findings. For example, in Japanese cancer consultations, the physician’s use of openended questions has been shown to be positively related to patient satisfaction. When patients asked more questions, they reported a significantly lower level of satisfaction (Ishikawaa, Takayamaa, Yamazakia, Sekia, & Katsumatab, 2002). In another study, active listening was shown to be an essential interview technique for physicians because the majority of patients express their concerns and expectations indirectly through verbal or behavioral cues (Lang, Floyd, & Beine, 2000), which are often culturally coded. Most importantly, research into physician responsiveness, defined as continual change in behavior in response to shifts in context and perceptions (Stiles, Honos-Webb, & Surko, 1998), shows that emerging characteristics of the physician–patient interaction cannot be addressed by scripted communication (Stiles, 2002). A study of scripted behavioral counseling on safety habits showed that the scripted communication failed to respond to individual needs that might influence behavioral change (Leverence et al., 2005). Physician–patient communication research indicates that a shared interview approach is needed to individualize the visit with information that emerges during the consultation (e.g., Piccolo et al., 2002). Listening to the patients’ stories to learn patients’ needs and preferences and communicate accordingly is deemed to be an essential part of patient-centered medicine (Bensing, 2000) and “narrative competence” (Charon, 2001). As noted in Walsh, Karliner, Burke, Somkin, and Pasick (2006), physicians participating in our study reported use of both physician- and patient-centered approaches.

Previous studies of provider–patient communication have relied on surveys, focus groups, and personal interviews exclusively, and their research findings are often based on self-reports of general attitudes, beliefs, and perceptions of CRC screening (e.g., Blanchard & Lurie, 2004; Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005), or solicited responses from closed-ended questions of existing measures (e.g., Sun, Basch, Wolf, & Li, 2004). Our study contributes to this rich area of research in its unique methodological approach, which enabled us to observe and analyze both physician-centered and scripted approaches, and more importantly, to ask patients to reflect on the actual performance of communication that took place during their office visits and to make sense of this on their own terms. As the findings discussed below illustrate, although attention to cultural issues was not obvious in the observed interactions, cultural themes were prominent in patient narratives reflecting on and interpreting the videotaped interaction.

Method

Patients and physicians were recruited at an urban, integrated health care delivery system serving an ethnically diverse patient population, and at three community clinics each serving predominantly one of these ethnic communities: African American, Latino, or Chinese. Several physicians were recruited through professional networks and via clinic directors. These physicians later recommended others. We also recruited additional physicians while in the clinics conducting the study. All procedures were approved by the Institutional Review Boards of participating institutions.

Eligible patients were 50 years or older, not up-to-date on CRC screening (never been screened; over a year since last fecal occult blood test (FOBT); over 5 years since last sigmoidoscopy or barium enema, or, in one setting, over 10 years since last sigmoidoscopy; or over 10 years since last colonoscopy), and were patients of participating physicians. Patients were approached in one of two ways. At community clinics, where many patients are highly mobile and not easily reached by mail, we recruited via waiting-room intercepts. Patients were asked if they were interested in participating in the study by a team member, and then administered informed consent. In the integrated health care system, eligible patients of participating physicians were identified in the central database. We then emailed the list of potential participants to physicians to obtain their permission to contact identified patients. Those approved by the physician were then sent a letter, signed by their physician, inviting them to participate. If we did not receive the return, preaddressed refusal card from the patient, we called him or her several days before the appointment to confirm interest and to ask that she or he arrive for the appointment 15 minutes early to allow for the consent process.

A research team member accompanied participating patients to the exam room, set up the video camera, and showed them how to use the remote to turn the camera on and off in case there was something discussed they did not wish recorded. We gave the physician the same instruction, with an additional explanation of how to place a drop cloth over the lens during a physical exam. Immediately after the visit, we brought patients to a private conference room where we viewed the videotape and discussed it using a technique called “stimulated recall.” In each interview, prior to viewing the video, we first asked participants general questions about their visit and what they discussed with their doctor. If the screening recommendation was mentioned in response to these general questions, we probed for understanding and recall. If not mentioned, we asked direct questions about the CRC-screening discussion and patients’ recollections of it. Then we asked patients to watch the video and stop the tape at any time they had any comments or thought of something they might like to discuss. At the same time, we noted areas of probing that we returned to after the participant-initiated pauses. We interviewed physicians about several visits at one time in a similar manner.

We exercised care in selecting bilingual interviewers and translators. As we know, selecting appropriate translators in research and consultation with bilingual experts is important for achieving equivalency in cross-cultural research (e.g., Carlson, 2000; Small et al., 1999). Our translators are not only experienced, but we have worked with them on other research projects. Our bilingual interviewers had prior experiences in conducting both group and individual interviews. For this project, they received one week of intensive training in which they conducted mock interviews with the project director (a medical anthropologist) and got feedback about areas of improvement. In addition, the project director reviewed and provided detailed feedback on the first two interviews with each interviewer. This was repeated periodically throughout the study to ensure interview consistency and quality. We also sought advice from bilingual experts on our research team to ensure both accuracy and appropriateness of the translated interview protocol.

All individual interviews were taped and transcribed. All identifiable information was removed from both the tapes and the transcripts. Interview transcripts and videotaped observations were reviewed, coded, and reconciled for trustworthiness by three sets of two research team members working with the project director. Two team members reviewed and coded each interview transcript and videotaped observation individually. These members then met with the project director to discuss and reconcile differences in interpretation of meaning. Discussions continued until consensus was reached. Reconciled codes were then entered into Atlas.ti ethnographic software (Atlas.ti Scientific Software Development, 2006), a qualitative software program designed to manage and organize qualitative data, and to facilitate multilevel analysis. We conducted three levels of qualitative analysis. The first level, described above, included parsing quotes from interview transcripts into coded segments of text. The second level included review of the codes developed to identify several groups of codes, or categories relevant to our research question. In our third level of analysis, we read and reread the narratives associated with the codes that were identified. We then generated prominent cultural themes reflective of the data and selected representative quotes associated with those themes.

Results

Participant Characteristics

Participants consisted of 24 women and 20 men. They ranged in age from 50 to 77 years, with an average age of 61 years. Among them, 13 were African Americans, 12 were Hispanics, 10 were Chinese, 7 were non-Hispanic Whites, and 2 were of mixed cultural heritage. In the Hispanic group, 7 were self-identified as Mexicans, 3 as Central Americans, 1 as Latino/Latin American, and 1 as Brazilian. Participants' spoken languages included English only (n = 21), Spanish (n = 9), Chinese (n = 8), and primary other plus English (n = 6).

Direct Observations

In direct observations of clinical visits, we found that physicians typically presented CRC-screening recommendations in a set narrative. The narrative was information-oriented and had a biomedical focus. Few explicit references to cultural/ethnic differences related to CRC screening were recorded either in physicians' narratives or patients' responses. The discussion of CRC-screening recommendation was predominately one-sided. That is, physicians engaged in most of the talk and few questions were either solicited by physicians or asked by patients, with one exception. The majority of physicians did, however, ask about family history of colon cancer. A typical narrative included discussions of early detection, definitions of polyps and sigmoidoscopy, CRC screening in relation to other screenings, descriptions of the test procedure, and explanations of colon cancer risk. Some physicians used personal testimonies in addressing concerns that patients might have about the test procedure (see Walsh et al., 2006). One notable cultural reference observed in direct observations was physicians' expressions of individualism (i.e., emphasis on self) with regard to CRC-screening decisions. Physicians emphasized the need for individual choices and autonomy by stating, "It's a worthwhile test," and "I strongly recommend that you go through cancer screening." By framing their views in an open and nonimposing manner, physicians demonstrated their respect for patients' independent self-concepts and recognition of patients' desires/abilities to make independent and individual decisions concerning screening. An emphasis on individual initiatives was also evident in physicians' narratives, such as, "What you're doing really is kind of taking charge of your health this way. You're not waiting for things to happen to you." The notion of self-empowerment (i.e., You are in control of your own destiny and you are responsible for your own health) reflects an individualistic approach to health, which might not apply to those who define themselves in relation to others and are influenced by others in their daily lives. Arguably, such expressions of individualism might not be as effective when patients do not endorse the same values.

Postvisit Interviews

In contrast to direct observations, where few explicit references to cultural/ethnic differences were found, several cultural themes emerged in postvisit interviews with patients when videotapes were used for stimulated recall. Patients talked about issues that were significant and culturally meaningful to them, such as power distance, trust, health beliefs, directness/indirectness, and an ability to listen. These themes depart from stereotypical generalizations of cultural/ethnic differences, as in the description of Chinese patients' primary concerns being quick healing, cost, and convenience (Smith, 1999). They instead addressed the interactive dimensions of interpersonal relationships between physicians and patients.

Individuals' cultural orientations influenced how they viewed the nature of physician–patient interactions, as is evident in the following discussion.

Power distance—One cultural theme involved the power distance between physicians and patients. Power distance denotes cultural configurations of various role expectations that govern institutional, social, and interpersonal relationships. In the context of physician–patient interactions, physicians and patients attach their own meanings to the socially prescribed role expectations and negotiate their space in the encounters. When patients feel that their relationship with their doctor is what they have envisioned, they are more likely to be receptive to their doctor's CRC-screening recommendation. Culture appeared to influence personal construals of such relationships. Patients gave accounts of different meanings and definitions of relationships with their physicians. Some patients described their relationship as equal, open, and close, and felt that physicians should spend time with and show concern for patients:

> I feel … he's just a regular old guy … he's not just the "doctor" … he's, I feel, very approachable. (equality)
>
> I can talk to him about anything. If I have any issues, I can talk to him as if he was my family member … the way it should be with a doctor. (openness and closeness)
>
> I think every doctor should take time with patients, each one of them, even if it means it uses up a whole lot of time. (time with patient)
>
> I like him because he is so concerned about his patients. (physician concern)

Other patients perceived their physicians as an authority figure, and their relationship as dependent and unequal. Patients looked up to physicians for their authoritative voice, knowledge, expertise, and credential. They expressed their dependency on their physicians for medical advice:

> Well, it gets comforting to have the doctor … you know, [say], "I really think it's the right thing to do," rather than, "Well, you can do it or not do it … it's your choice. (authoritative voice)
>
> Well, you know, I don't have the knowledge that he does of what he's trying to explain to me, and so I'm trying to be agreeable to what he's telling me. (knowledge)
>
> You know your doctor's like your mechanic. He's supposed to keep you going. He comes and says, "Well, I suggest this and that." And that's what your doctor is supposed to be like. (expertise)
>
> A lot of things that he's going to say—I didn't understand it … you have to go to college, you have to have a medical degree and all that. (credential)
>
> I rely on their judgment … so when he says, "Take it," I take it. (dependency)

In addition, patients articulated specific behaviors of physicians that were perceived to help inform such a relationship. One behavior involves physicians making personal contact with patients. Patients recognized communicative acts that physicians engaged in to make them feel the personal connection, such as "personal talk," "joking," "sharing personal experiences," "asking how things are," "shaking hands," and "being involved in patients' talk." Patients also recognized physicians acting as a resource for patients and making themselves available to answer patients' questions:

> He doesn't waste a lot of time … but he takes a little bit … a little personal talk. You feel like there's someone that knows you personally. So, he's very convincing. (personal talk)

> He's willing to joke with me a little bit, as well as share some of his own personal experiences. I think that's a big positive in terms of communicating with a patient and putting a patient more at ease, in being able to relate to his or her doctor. (joking, sharing personal experiences)

> But I think, like any good doctor, he asks me about general things and how are things going … to get an idea about where I am. (asking how things are)

> Dr. [name] always comes in and shakes your hand, and he just makes a little, you know, personal contact, which I find very helpful. (shaking hands)

> With her there's conversation … that you don't feel any kind of pressure, in fact once there, sometimes even family issues come up or … it's not like, "Let's get to the point and we are done for today; here is your medicine," and that's the end of it. But rather, she gets involved, she has, more of a relationship with you. (involved in patient's talk)

> I have a question, you know, I usually call him [doctor] … I mean if I don't have an appointment with him…. If my mother has problems, and we don't know what to do, I can call Dr. [name] on the phone… like I said, he's a good doctor. (resource)

For some patients, power distance was an evolving concept. Arguably, developing a relationship not only takes time, but is essential to effective physician–patient communication, as in the case of one patient who would hold back things until he developed a relationship with his doctor, as he described how his relationship with his doctor had evolved over the years:

> I've been coming to see Dr. [name] now for about three or four years. I was apprehensive at first because I didn't know too much about him. But as I continue to see him we open up to each other, like you're seeing us do right here … I mean I can share things with him like my physical health that I couldn't share with other doctors. I didn't know them—they didn't know me.

Trust—Trust is another cultural theme that influenced patients' response to CRC-screening recommendation. Patients appeared to be more receptive when they expressed trust in their doctor. Even though "trust" is a pivotal concept in the physician–patient relationship, differences exist in from whence patients derived their meanings of trust (i.e., sources of trust). For some patients, trust came from personal experiences or perceptions of physician competence. For others, trust meant confidence. The phrase, "a good doctor," was repeatedly used by patients, and is almost synonymous to trust:

> I told him I had no worries…. He is a good doctor, though. He had some stuff in his closet that got my blood pressure to 120/80. (experience of competence)

> I was reluctant to get it at first but I went ahead and did it because she recommended it…. I don't question too much about her … she's very good. (perception of competence)

> If he says that something is necessary, I believe him. And he's protecting my interests … I just, you know, have confidence in him. (confidence)

> I think he's a good [doctor]—he's looking out for my welfare. And that's what I always liked about it. (perception of doctor protecting patients' interest)

> I don't argue with it. You know, because, he's the doctor. And he's the one that watches out for me, so … He never asks me to do anything that he wouldn't do, you know. (experience of doctor protecting patients' interests)

A sense of distrust also emerged in patients' accounts. Resistance to CRC-screening recommendation involves a sense of distrust, and the sources of distrust varied among patients. Mistreatment because of low socioeconomic status, not being in control, and negative ethnic stereotyping represent some of the fears described by patients. Patients also expressed their suspicion of the health care system and the CRC-screening promotion:

> Because I'm a clinic patient and a lot of times [that hurts]: "Let's try this and let's try that. She is a clinic patient!" … Yeah, I mean, you go to a clinic and you're not paying full price so … (fear of mistreatment)

> What I don't want to see happen with a cancer or potential cancer situation is something looks suspicious, and they do a radical operation, without even asking me. So I want to make sure that that's not what I'm setting myself up for. (fear of not being in control)

> I want to know what's happening to me, not just be an experiment thing, you know, a guinea pig or something. And like I said, if I know what's happening to me I can relax more. I don't have to be afraid or anything like that. (suspicion of health care system)

> It seems to me like this is something new that they're starting to push. And maybe it's for people's benefit but all of a sudden it comes up real big, you know. And, I don't know. (suspicion of CRC-screening promotion)

Health beliefs—Health beliefs also influenced patients' responses to CRC-screening recommendation. Patients recounted different cultural beliefs that supported their resistance to CRC screening. Fatalism was one such belief. Patients also expressed the belief that all cancer kills, thus deeming intervention and early detection a futile exercise. Some expressed that removal of cancer could make cancer grow back and spread. These health beliefs can reduce or diminish the effectiveness of any intervention or early-detection discussion:

> Well, you know in everything—just like I told you, people die…. So that's just life, honey. (fatalism)

> I said all cancer kills. Don't be telling about some cancer that can kill you. All that "shit" kills in due time, just like he said…. And I told him about—because I had a sister who had her breast cut off and after a while they cut off another. And eventually she died. And then they say some people live. (all cancer kills)

> Sometimes cutting things away also makes them grow back. Well, if they get malignant—like with breast cancer, you can cut it and the tumors spread even worse. So sometimes I wonder about taking it away, if it'll make it spread and open it up and make it spread. (removal making cancer grow and spread)

In contrast, the belief of taking control of one's own health and being proactive motivated some patients to undergo screening. As one patient explained, "If you catch it in time, you'll get cured." The role of one's health belief in screening is clearly exemplified in the following account:

> I know I tell a lot of my—well, not a lot, but male friends about prostate and everything. They don't want to hear, especially men: "I don't want to talk about it. I don't want to hear it." So I try to tell you before you get to the point where it's too late or you start to suffer. And I notice that we [African Americans] don't want to

> know about it and we're not ones to really read up on it or really give back on experiences.

Directness/indirectness—Physicians' direct vs. indirect style of communication was identified as a cultural theme in patients' responses to CRC-screening recommendation. Overall, regardless of their ethnic/cultural background, patients preferred that physicians be direct in their communication. Patients expressed that they want their physicians to inform them about what's going on and to give them full disclosure. Patients also attributed different meanings to physician direct communication. Getting to the point, being clear, giving all the information, and being open and blunt were recognized as examples of direct communication:

> Well, okay … just laying it out on the table. (informed)

> Just tell me … good or bad … don't beat around the bush with me. (full disclosure; open)

> He gets to the point … tells you what you want to know … explain things that you don't know. (getting to the point)

> He's very good with being willing to give all the information. (giving all the information)

> And he's very clear in explaining things … that's what I like. I perceive him to be so forthright and straight-shooter that no B.S…. you feel that they're not holding anything back … And you feel … you know, they're not patronizing you … that they're telling you exactly what's happening…. With me, that's real important. (clear and open)

Ability to listen—An ability to listen also emerged as a cultural theme in patient interviews. Patients explained how their physicians' listening ability helped define and shape the relationship they have. As one patient explained, a physician's ability to listen helps create a comfortable atmosphere for patients to engage in self-disclosure. To some, listening showed a physician's interest in the patient as a person. To others, listening meant an equal physician–patient relationship. Listening also meant that the physician was helpful and easy to talk to. Listening, therefore, is an important communication act that mediates the physician–patient relationship:

> He listens … he's interested in finding out about me as a person. (interest in patient as a person)

> He seems like he really does listen and spend time and answer questions well … easy to talk to and thorough. (doctor helpful and easy to talk to)

> Because I prefer to be able to communicate and not be afraid, you have to kind of reveal yourself, to get to, to the doctor. And then I have to be comfortable that he's going to listen, and not cut me off, or not look at me as a disease walking around, that needs to be cured, you know. (comfortable atmosphere for self-disclosure)

> I like talking to Dr. [name] because I believe that he listens to what I'm saying. And, then, I get to have my input into what's happening to me…. That's the good thing because you're able to talk to someone and they're just not kinda giving you orders, then that allows you to feel more comfortable with that person because they're not trying to be dominant over you. (equal relationship)

Discussion

The purpose of our research was to explore how African American, Chinese, and Latino patients view effective communication in their medical encounters that included a CRC-screening recommendation, and how culture influenced their definitions of effective communication. We found that interpersonal relationship themes such as power distance, trust, directness/indirectness, and an ability to listen, as well as personal health beliefs, emerged as important factors affecting patient definitions of effective communication. In addition, we found that physicians did not solicit or directly address cultural barriers to CRC screening, and patients did not volunteer culture-related concerns they might have regarding CRC screening. Below we discuss our findings in more detail.

Our inability to find explicit references to cultural differences in physicians' CRC-screening recommendations or in patients' responses can be attributed to several explanations. One plausible explanation is that CRC-screening talk is often scripted. When physicians engage in scripted communication, they often operate on "automatic pilot," thus reducing the potential to tailor messages culturally or individually (assuming the physician is aware of how to do so, or why it is important to do so). Tailoring is the adaptation of the intervention, and/or a total redesign to best fit the needs and characteristics of a target audience (Pasick, D'Onofrio, & Otero-Sabogal, 1996). Cultural tailoring is the development of interventions, strategies, messages, and materials to conform to specific cultural characteristics (Pasick et al., 1996). In our analyses of direct observations, we found little variation in CRC-screening talk given by one physician across several patients. Another explanation might be that, in discordant physician–patient encounters (when each is from a different ethnic group), physicians might not be aware of the need to culturally tailor; if they are aware of the need, they might not know how. Physicians' self-awareness of the dangers of stereotyping might also account for the lack of cultural tailoring.

With regard to the finding that patients tended not to disclose culturally based concerns that they might have concerning CRC screening, one possible reason is that in scripted communication, there is little room for free exchanges of information. The structure of such interaction thus limits self-disclosure of personal concerns. As shown in direct observations, physicians often presented an uninterrupted narrative, and only at the end of the narrative were patients asked if they had any questions. Scripted communication is not conducive to manifestations and revelation of significant and relevant behaviors, as shown in Blackman's (2002) study. Another reason could be attributed to the power distance between providers and patients. Patients might feel that such information ought to be solicited, not volunteered, as evident in postvisit interviews. We can also posit that, in discordant encounters, patients might either feel inhibited or uncomfortable disclosing such information because they think physicians of a different cultural background might not understand their concerns. Consequently, this type of disclosure might be more likely to transpire in concordant encounters in which providers and patients share similar cultural assumptions and expectations.

Power distance was found to be a key cultural theme in our research. We found pronounced differences in expectations of low power distance and high power distance, as well as differences in conceptions, perceptions, and expectations of physician–patient relationships, in different cultural groups. That is, whether a visit to the doctor constitutes a personal encounter and engagement, or an impersonal and business-like transaction, differs among patients of varying backgrounds. Effective physician–patient interaction might require that physicians know how patients define and expect power distance by administering patient assessment (e.g., My doctor is someone who gives expert advice; My doctor is someone to whom I can talk about my medical problems). It is also important for physicians to understand that a relationship might take a long time to develop in some cultures, as shown in patient interviews. A lack of self-disclosure of relevant information on the part of the patient could be a barrier in providing quality care, as found in Ngo-Metzger and colleagues' (2003) study. Asian immigrant patients demonstrated reluctance in disclosing their use of traditional medicine to their physicians because they feared possible negative reactions, or a lack of understanding on the part of the clinician. It is worth noting that engaging in personal talk, telling jokes, sharing personal experiences, and shaking hands are examples of communicative acts that patients found to be meaningful in their relationship with their physician.

Trust is another important cultural theme in the effectiveness of CRC-screening recommendations. Our findings showed how patients related to trust, how they made sense of trust in the context of their relationships with their physicians, and how they differed with regard to sources of trust. Arguably, in discordant interactions, trust might compensate for or mitigate the effect of the absence of culture-tailored communication. Thus, developing a trusting relationship is central to increasing the quality of physician– patient communication. Through analysis of physician strategies and patient perceptions of these strategies, Burke and colleagues (2005) drew the same conclusion. Although physicians did not perceive their behaviors and strategies as culturally informed (as evidenced in their review of videotaped CRC discussions), patients interpreted them as culturally resonant, thus leading to a deepening of relationship and trust with their physicians. Our analysis extends this finding to note that patients who trusted their physician saw their physician as competent, or as their advocate. This finding is consistent with prior work that identified trust or continuity as a promoter to CRC screening (O'Malley, Beaton, Yabroff, Abramson, & Mandelblatt, 2004).

In contrast, the feeling of distrust went beyond the office visit. Patients talked about their fear of being victimized by the system, fear of negative racial prejudice, and past negative experiences with health care. Prior work has shown similar suspicion of the motives of the health care system and of the advocate role of physicians (Greiner, Born, Nollen, & Ahluwalia, 2005), as well as perceptions of unfair treatment because of race or low income (Blanchard & Lurie, 2004; Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999; Freimuth et al., 2001; Gamble, 1997; Gregg & Curry, 1994; O'Malley et al., 2004). This finding suggests that building trust is extremely important, especially among cultural groups in which trust has been questioned and in which differences exist in terms of the source of trust (role-directed vs. relationship-directed), and how individuals build trust.

In addition to all of the above issues, patients' health beliefs influenced how they receive CRC-screening recommendation and the perception of its effectiveness. Patients who were supportive of preventive care and early detection were more receptive to screening tests and were more motivated. This finding is consistent with prior work in a study of urban African Americans, in which hope was associated with CRC and other cancer screening tests, and anticipation of positive outcomes was seen as a source of hope (Greiner et al., 2005). Passive acceptance of cancer and misconceptions about how cancer spreads, however, have also been shown to contribute to resistance to screening (Gregg & Curry, 1994; Greiner et al., 2005; O'Malley et al., 2004). In addition, fear of learning they had cancer was an important barrier for Hispanic women to overcome in Pap screening (Vanslyke et al., 2008).

A physician's communication style constitutes another influential aspect. Patients across different cultural/ethnic groups preferred that their physicians communicate with them in a direct and an explicit way, as demonstrated in patient interviews. Patients also perceived direct and explicit communication as indicators of honesty and trustworthiness. This finding indicates that, despite differences of cultural backgrounds, patients favored a low-context communication style that is direct and explicit, and they attached positive meanings to directness. An ability to listen is another theme that influenced physician–patient interaction. Patients felt that they could relate, talk, and disclose to their physicians if physicians showed an interest in listening. Effective physician–patient communication requires that physicians engage in active listening. Active listening has been identified as a key component of patient-centered health care (e.g., Bensing, 2000; Charon, 2001; Lang et al., 2000), and physicians' capacity for active listening was perceived as a valued quality by patients (Oliffe & Thorne, 2007).

This study has several limitations that are worth noting, and might affect the generalizability of our results. First, our sample size was relatively small because of the intensive nature of our research. Second, a large number of the patients who were observed and interviewed had established relationships with their physicians, particularly in the integrated health care system. Third, the study was limited in scope because our design focused on discordant communication. It would be useful in future studies to observe and compare both discordant and concordant encounters. Fourth, we did not follow patients to ascertain whether or not they followed through with colorectal screening. However, as a developmental study exploring the role of culture in communication, this was beyond the scope of our study. Despite these limitations, this study is significant because the findings show that health communication research on such topics as CRC-screening recommendations should be examined in a broad cultural context. That is, we need not only to investigate specific CRC-screening recommendations and strategies, but to consider other cultural aspects that mediate the effects of such efforts and are central to patients' overall experience with their physician. Such necessity was evident in prior work (Zapka et al., 2004). In addition, our findings were based on a rare combination of direct observations and postvisit interviews, thus providing an in-depth examination of cultural issues that were specific to each individual's circumstances. Our findings, though limited in sample size, provided thick descriptions of how patients made sense of their physicians' CRC-screening recommendations, and what was meaningful to them (Geertz, 1973).

Acknowledgments

Authors' Note: This work was supported by a grant from the National Cancer Institute (CA RO1 CA 95594-01, Pasick, PI), "Cross-Cultural Communication and Cancer Screening." We thank the physicians, clinics, and patients who gave us their time and attention. We also thank our excellent group of interviewers: Claudia Guerra, Keisha Tyler, Daramola Cabral, and Galen Joseph.

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