THE IMPACT OF INTERCULTURAL COMMUNICATION ON PHYSICIAN-PATIENT RELATIONS IN ISRAEL

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by

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Dedicated in memory of my beloved father,

Dr. Elchanan Hans Eger, my mentor and inspiration,

a person of knowledge and love of mankind.

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Abstract

Background: In Israel, medical encounters often bring together physicians and patients from different cultures, whose values, beliefs, expectations, and needs concerning health and health care are likely to vary.

Aims: The study aims to elicit patients' culturally based beliefs, attitudes and behaviours in order to increase intercultural sensitivity and understanding among physicians and enhance effective communication between physicians and patients in Israel.

Methodology: The study sample consisted of adult patients from three cultural groups—Jewish-Israeli (JI), Arab-Israeli (AI), and immigrants from the former Soviet Union (FSU)—and comprised nine groups, categorized by different cultural combinations in physician-patient dyads. The main research tool was an Attitude and Satisfaction Questionnaire, which included forty-six statements related to different variables of physician communication during the encounter. Thirty additional in-depth patient interviews were conducted in order to further understand how patients evaluate the aspects addressed in the study.

Setting: The study was conducted in the outpatient clinics of Bnai Zion Medical Centre in Haifa, Israel over an eight-month period in 2003. The patient sample included 110 patients in each of the nine groups, for a total of 990 patients. After leaving the encounter, each patient was interviewed individually by a language-concordant interviewer.

Participants: All patients were at least 21 years old. The JI patients were either born in Israel or had been living in Israel at least 20 years. All the FSU immigrant patients immigrated to Israel after 1988. All the physicians were specialists and board certified in their medical fields. Russian-Israeli physicians all graduated from medical school in the FSU. Every group included an equal number of male and female patients (55).

Hypotheses: (1) Patients from the three culture groups will exhibit differences in attitudes, needs, expectations, and satisfaction regarding the examined aspects of the medical encounter. (2) Patients from the three culture groups will exhibit differences in attitudes, needs, expectations, and satisfaction with respect to the interaction between patient and physician culture. (3) Patients in culture-congruent groups will report that their needs, expectations and satisfaction were met to a higher degree than will patients in culture-incongruent groups.

Results: *Hypothesis No. 1*- Statistically significant differences were found between the patients from the three cultures for all the examined variables. JI patients, compared to AI and FSU immigrant patients, sought and received more medical information, were more interested in becoming partners in participatory decision-making (PDM) with their physicians, reported that their physicians were more open to PDM, expressed a greater desire to consult with other sources concerning their medical problems and treatment, evaluated their physician's interpersonal communication more positively, were more satisfied with their physician's courtesy, and did not suffer from problems deriving from language barriers and lack of time. Compared to FSU immigrants, AI patients sought and received more medical information, evaluated their physician's interpersonal communication more positively and experienced fewer language difficulties. AI patients also expressed a greater need for improvement in the encounter than did JI patients, as well as a greater need for time to get acquainted with the physician compared to the other two groups. Compared to JI patients, FSU immigrant patients were less satisfied with their medical treatment and suffered more from lack of time. They also experienced more language difficulties than did AI patients and expressed a greater preference to be examined by language-concordant physicians than either of the other two groups.

Hypothesis No .2- The findings indicate an interaction between patient and physician culture with respect to patient attitudes, needs, and satisfaction. JI patients sought and received more information from culture congruent physicians. When seen by Russian-Israeli physician, JI patients expressed an increase desire for PDM, an increased need for improvement in the encounter, reduced satisfaction with the physician's medical treatment and courtesy, and a greater desire to be examined by language-concordant physicians. They also suffered more from lack of time. When treated by either JI or AI physicians rather than Russian-Israeli physicians, AI patients sought and received more information, evaluated physician's interpersonal communication more positively, were more satisfied with physician courtesy and experienced fewer language difficulties and lack of time. When seen by JI physicians, FSU immigrant patients expressed an increased desire for PDM and were less satisfied by physician courtesy. When seen by culture-congruent physicians rather than either JI or AI physicians, they evaluated physician interpersonal communication more positively, experienced fewer language difficulties and expressed a preference for language-concordant physicians. They also evaluated the interpersonal communication of AI physicians less positively than that of JI physicians.

Hypothesis No. 3- Patients from culture-congruent groups reported that physicians were more open to PDM. They evaluated physician interpersonal communication more positively, were

more satisfied with physician medical treatment and courtesy and experienced fewer language difficulties. Patients from culture-incongruent groups reported that they sought less and that physicians offered less information. Culture-incongruent dyads also exhibited an increased desire for PDM and expressed a greater need for improvement in the encounter and for language-concordant physicians. None of the reported differences were found to be gender-dependent.

Conclusions: JI patients exhibited needs and behaviours that may be interpreted as individualistic and consumerist. They assumed more bargaining power in the patient-physician relationship than either of the other patient groups. AI patients, as members of a collectivistic culture, exhibited unique cultural and religious behaviours. They respected their physicians and trusted them to have all the necessary knowledge and information. JI and AI physicians seemed to meet the expectations of both JI and AI patients more satisfactorily than did Russian-Israeli physicians.

While FSU immigrant patients seemed to conform to the Russian model of medicine, they also appeared to suffer from a conflict between their desire to benefit from modern Israeli health care and their inability to behave accordingly. Russian-Israeli physicians seemed to meet their needs more satisfactorily than did either JI or AI physicians.

The characteristics and differences identified in this study may have the power to inform and sensitize health care professionals to the needs of their patients, specifically the need to elicit narratives within a patient's cultural context and to seek to uncover each patient's individual voice. By listening to each patient while recognizing the multiple cultural contexts involved- those of the patient, the physician and of medicine itself- health care providers may be able to negotiate among cultural differences to reach mutually desired health care goals, and thus provide treatment that best serves the interests of the individual patient.

Chapter 1 Introduction

"May I never see in the patient anything but a fellow creature in pain."
The oath of Maimonides, Moses Maimonides (1135/38-1204)

1.1 Preface

Health care providers as well as consumers are likely to approach health care situations with their unique health beliefs, health behaviours and communication styles. Cultural differences and other potential barriers may significantly influence health communication and the provision of effective and satisfying health care.

Contemporary Israel is characterized by a heterogeneous social structure that has been shaped by a variety of forces and circumstances, among them immigration patterns, the growing Arab-Israeli minority, and religious diversity. Moreover, health care in Israel comprises large numbers of foreign-born and foreign-educated physicians as well as patients. The contingent of doctors in Israel comprises Jewish-Israeli, Arab-Israeli, and Jewish-foreign born physicians, mostly immigrants from the former Soviet Union. The contingent of patients comprises Israeli-born Jewish and Arab patients, as well as a large number of Jewish immigrant patients from a variety of countries, with a significant number from the former Soviet Union.

Thus, the medical encounter in Israel often brings together physician and patient from different cultures, who are likely to have varying values, beliefs, expectations, and needs concerning health and health care. Their ability to establish effective communication may positively influence their relations and the success, satisfaction and outcomes of the medical encounter.

1.1.1 Study aims

The study aims to elicit patients' culturally based health beliefs, attitudes and behaviours in order to increase physicians' intercultural sensitivity and understanding, and enhance effective communication between physicians and patients in Israel.

1.1.2 Study objectives

The study explores various aspects of the medical encounter that are believed to be affected by culturally-based expectations and behaviours of physicians and patients, and hence to affect the physician-patient interaction. Specifically, the objectives are as follows:

1) To examine how the physician culture and patient culture influence the communicative process during the medical encounter, by comparing culture-congruent and culture-incongruent physician-patient dyads.

2) To elicit patients' preferences concerning the examined aspects of the medical encounter.

3) To examine the extent to which patients' needs and expectations are met by physicians in culture-congruent and culture-incongruent dyads.

1.2 Background

Following World War I, the British Mandate of Palestine served as the setting for the development of a small, autonomous Jewish community that sought to realize the goals of the pioneer ethic of Zionism, through an emphasis on collective responsibility, egalitarianism, physical labour, agricultural settlement, and democracy. The pre-state Jewish community emphasized the centrality of nation-building, independence, security, and free immigration. In 1948, when independence was attained, the Jewish community numbered 650,000. The size and heterogeneity of the community increased rapidly with the arrival of more than 700,000 immigrants, resulting in some diffusion of the early values, which were less meaningful to European Holocaust survivors and immigrants from Muslim countries.

One of the first legislative acts passed by the Knesset (parliament) after the Israeli Declaration of Independence in 1948 was the Law of Return, which stated that every Jew has the right to immigrate and settle in Israel. The acceptance and integration of Jewish immigrants continues to represent one of the cardinal values of Israeli society, which has always allocated major resources to the absorption process. In 1990, with the large wave of immigration from the former Soviet Union (FSU), the economic and social needs of the immigrants placed an increasingly heavy burden on the state.

The differences in the countries of origin of the initial immigrant populations established long-term patterns of social stratification in Israel society. The Jewish immigrants included Holocaust survivors from Europe, as well as those from East European countries, Mediterranean countries of North Africa, and Afro-Asian Jewish communities, thus creating an extraordinarily heterogeneous society. The lines of differentiation, defined by educational background, occupational skills, and closeness to those located in positions of power, were drawn along socioethnic lines defined by continent of origin. On the whole, individuals and groups originating from Asia and Africa ranked lower than groups of European-American descent (Shuval 1992). The linkage of ethnicity, which in the Israeli context refers to the country of origin of immigrants and to socioeconomic status, resulted in a rank ordering of

ethnic groups in the society that persists to this day (Smooha 1978, Shuval 1989,). Each of these rough groupings includes tens of specific groups that differ from each other with regard to their cultural traditions. The consensual values offered to immigrants as a means of becoming Israeli were strongly Western in orientation, such as achievement, social mobility, careerism, and material goals. The process was accompanied by stereotyping and prejudice as well as self-rejection among the Asian-African immigrants. Among the more tenacious cultural traditions that have persisted despite widespread Westernization are some that are relevant to health behaviour: attitudes to food, patterns of nutrition, response to pain, reliance on traditional remedies, patterns of solidarity and social support among family members, and levels of dependency.

A large proportion of Israeli Jews are themselves immigrants or the children of immigrants. The experience of immigration and of adjustment to a new society defines the underlying facts of life for major segments of the population (Shuval 1992). The transformation of prior coping mechanisms to meet new needs and to address unfamiliar situations take time and skill, and many immigrants are therefore under stress for various periods of time (Antonovsky 1979). Many first- and second-generation Holocaust survivors carry scars of trauma for indeterminate periods of time. Early traumatic experiences of the refugees from Ethiopia and the older FSU immigrants have weakened their coping skills, making them more vulnerable to new stressors. Immigrants imported a variety of diseases from their countries of origin, some of them chronic and other infectious. Life styles and environmental conditions in the FSU were characterized by high incidence of smoking, alcoholism, poor dietary practices, and poor living conditions (Shuval 1992).

1.2.1 Demographic data

The data refer to the end of 2003. The total population of Israel was 6,748,400, of which 5,165,400 were Jewish-Israeli. About 40% of the world's Jews lived in Israel. Of the total of 1,325,700 Arab-Israelis, 1,072,500 were Muslims, 142,400 were Christians and 110,800 were Druze. FSU immigrants who arrived during the immigration wave of the 1990s numbered 908,400 (Israel Central Bureau of Statistics).

The total number of physicians (up to age 65) was 24,577, of whom immigrant physicians numbered 9,759, with 8,363 immigrant physicians from Eastern Europe. 40% of all physicians were women, with women numbering 53% of immigrant physicians (Ministry of health).

1.2.2 The Arab-Israeli minority

Israel's War of Independence resulted in a mass exodus of Arabs. Those who remained were the less urban, less educated segment of the Arab population. In 1948 Arabs constituted 13.6% of the total population; by 2003 their numbers had grown to 19.6 % of Israel's population. The Arabs in Israel are composed of three sub-groups defined by religion: the largest group is the Muslims (80%), followed by the Christians (11.7%) and the Druze (8.3%). The three groups differ in socioeconomic level and in education. Most Christians live in urban communities and are characterized by relatively higher socioeconomic status and education; the other two groups are principally rural. The ongoing political conflict between Israel and the neighbouring Arab countries has been a constant underlying theme in relations between Jews and Arabs in Israel, exacerbated by differences in religion, language, and culture. The cumulative effects of the conflict are seen in widespread hostility, intolerance, and negative stereotyping in both segments of the population. By the 1980s the Arab minority had undergone a major transformation seen in an established middle class, a vocal, educated leadership, a network of organizations, and a willingness to fight for its legitimate rights within the Israeli democratic system. The health implications of the ambiguous status of the Arab-Israeli minority are seen in three areas: ongoing traditionalism in some aspects of social life, especially in the context of the village population, which is accompanied by health-related behaviours and attitudes; social and political alienation, accompanied by a deep sense of deprivation; and underdevelopment of the infrastructure of health and welfare services (Shuval 1992).

1.2.3 The 1990s FSU immigrants

By the end of 1999, the wave of immigration that began in 1989 had brought almost 980,000 immigrants to Israel, including 85% from the FSU. Along with another 200,000 immigrants from the FSU who arrived prior to 1989, they constitute the largest single group of immigrants to Israel from a single country of origin. The 1990s wave is typified by great ethnic and sociocultural diversity: over three quarters are Jews of European origin, while the rest come from the Caucasus and Central Asia (Remennick 1998).

These new immigrants joined a society that was undergoing significant change: from a centralized to a decentralized regime; from a high degree of governmental involvement in the economy to a moderate market economy integrated into the world economy; and from a small society with a single dominant culture into a pluralistic and heterogeneous society, with an increasing sectarian orientation of an ethnic and religious nature that weakens collective values and provides legitimacy and political expression to the demands and values of various

sub-groups within the Jewish population (Leshem 1997). Significant differences exist between the demographic and social attributes of the FSU immigrants and those of the Jewish sector of their absorbing society. There are relatively more women and elderly among the immigrants, fewer children, more single-parent and multigenerational families, and a significant proportion of religiously mixed families. The immigrants tend to have more years of education than the veteran population, and both male and female immigrants had a higher participation rate in the labour force in the FSU than is typical for Israelis. The immigrants brought their own language and shared world of symbols and values derived from social and cultural traits of the Soviet cultures. These characteristics, combined with the large numbers of immigrants to Israel in the 1990s, have had a significant impact on the intensity of change in contemporary Israeli society, as well as on their integration (Al-Haj 2000). Al-Haj (2000) reported that on the whole, FSU 1990s immigrants are satisfied with their absorption, and their feeling of being "at home" in Israel increases with length of time in the country, family income, and command of Hebrew. Nonetheless, a significant number cited a sense of financial distress, loss of socioeconomic status, and the lack of verbal communication, especially among the elderly. A considerable amount of conflict between immigrants and veteran Israelis is reflected in perceptions, for example that Israelis tend to exploit or be indifferent to immigrants and that immigrants tend to evaluate their own impact on Israeli society as more positive than that of Israeli society on themselves. The immigrants' social networks tend to be limited by their own group boundaries, social relations with veteran Israelis are mostly formal, and they tend to live in neighbourhoods composed of at least one-third immigrants. The immigrants feel socially closest to secular and Ashkenazim (Jews from Euro-American origin), and farthest from Arab-Israelis.

1.2.4 Reactions to the 1990s FSU immigration

The national consensus among the Jewish population regarding *aliyah* (immigration) is reflected in its reaction to the last wave of Soviet immigration. The vitality of the immigration and the need to attract Soviet Jews were never a matter of dispute. Leaders and the public have perceived this immigration as an historical event that served to uplift the morale of the Israeli population (Brital 1990). The Jewish leaders talked about the chance of using immigration to remedy long-standing fears of demographic dangers, both numerically and in terms of territorial presence. Some views were voiced against the resources allocated to absorption of the mass immigrant influx and the economic privileges given to immigrants considering the slow economic growth and increasing unemployment rates (AL-Haj 1993).

Arab-Israeli leaders expressed reservations toward the large-scale Soviet Jewish immigration, but not active opposition. Their concerns can be placed under the headings of group status,

individual risk, and potential threat to the national cause. Indeed, they are convinced that the status of the Arab minority in Israel will be further marginalized in consequence of the large Jewish immigration, and they fear their bargaining position in the Israeli economy might be harmed for both high-ranking positions and for manual and unskilled labour. At the national level, the immigrants are perceived as a potential threat to the Palestinian cause (Al-Haj 1991, 1993). The Arab-Israeli public ranks the contribution of immigrants to the economy less positively than their contribution to Israeli culture. Arabs have been deeply exposed to the culture and lifestyles of the Jewish majority, which are perceived as agents of modernization. This might explain the fact that the Arab population evaluates positively the potential cultural contribution of the Russian immigrants to Israeli culture. The same attitude, that the Russian immigration is composed of a high percentage of educated and professional people, is well founded in Jewish-Israeli society (Al-Haj 1993).

1.2.5 FSU immigrant physicians

The Soviet Union has been an important source of immigrant physicians in recent years. From the 1970s through 1987, a total of 6,751 immigrant physicians came to Israel, of whom 64% were women, reflecting the gender balance of the medical profession in the Soviet Union (Shuval 1983, Shuval 1992). Beginning in 1989, a large wave of immigration from the FSU brought unprecedented numbers of additional physicians. Yet, due to current access to medical personnel, along with differences in medical education, medical specialization and inadequate equipment in the FSU health care system, the health care system has been able to employ only a minority of them as specialists. As of 1987, physicians trained outside Israel have been required to take formal examinations before they can be licensed for general practice. Procedures for specialty practice require formal examinations administered by the Scientific Council of the Israel Medical Association. A mechanism utilized to maximize employment of immigrant physicians in the health care system is the allocation of medical personnel differentiated by locus of practice, so that immigrants without specialty status are largely employed in primary care clinics rather than in the hospital system (Shuval 1992).

1.2.6 Israeli system of health care

The Israeli health care system combines elements of socialized medicine, in terms of universal access, and managed care based on market-consumerist principles, which include choice of provider (the sick fund and doctors within it), possible variations in the services basket, and the coexistence of public and private sectors (Remennick 1998). The strong egalitarian welfare ideology provides support for a broad network of health care institutions providing extensive curative and preventive services to the population. The population is

covered by comprehensive health insurance through sick fund institutions, which includes curative and preventive ambulatory care as well as hospitalization. Physician contact rates in the Jewish population are among the highest in the world. Evidence from other societies indicates that Jews place a high value on health and are frequent consumers of medical services. Preservation of health may be viewed as an individually controlled survival mechanism in a people that has been subjected to existential threats. Jews have been found to show greater sensitivity to pain, greater awareness of health issues, and more frequent use of professional health care services. As in other societies, there are a wide variety of healers who provide supplementary, often simultaneous services outside the framework of the biomedical system. The group of traditional healers includes rabbis and other charismatic religious figures whose power and authority stem from traditional beliefs. In the ethnically heterogeneous population of Israel, these healers may be found in various segments of the Jewish sector, in the Arab sector, and among the Bedouin. Social and cultural closeness of healer and patient enhance the likelihood of effective therapy. A heterogeneous variety of alternative health practitioners is increasing in Israel; these include specialists in acupuncture, shiatsu, homeopathy, chiropractics, herbal medicine, reflexology, relaxation techniques, and many other areas. Until recently, the attitude of physicians and of the health care system has ranged from denigration to mild acceptance of selected practitioners. In recent years, however, physicians have shown increasing tolerance to patients, and evidence suggests a pattern of co-optation that maintains physician dominance while providing conditional legitimization for physician-selected alternative health practitioners (Shuval 1992).

1.2.7 Summary

Israel is a state based on immigration and is continuously preoccupied by further absorption of immigrants. Ethnicity is a basic social and cultural feature of Israel's social fabric. Social stratification is based on ethnicity-nationality distributed on two levels: Jews and non-Jews, and within the Jewish population, Jews of Euro-American origin – Ashkenazim, and Jews of Asian and African origin – Sephardim (Semyonov 1981). Fundamental differences exist between the inter-Jewish and the Jewish-Arab ethnic rifts with respect to both culture and membership (Ben-Rafael 1982). Thus, the Israeli patient cohort may exhibit a whole range of variance as health care consumers. The complexity of the social fabric in Israel casts an additional burden on the multidimensional character of the medical encounter, and strengthens the need to explore the underlying differences in Israeli patients' cultural characteristics and their impact on physician-patient relations.

Chapter 2 Literature Review

Health communication is concerned with how humans interact in the health care process. Effective physician-patient communication has been found to be positively related to patient satisfaction, patient compliance with treatment, and medical outcomes. The following literature review addresses seven topics that were found to affect the physician-patient relationship, and were therefore emphasized in the field study: culture, information, decision-making, physician's interpersonal communication, verbal communication, time, and patient satisfaction. Additionally, the topic of gender was reviewed, as two dimensions of gender were explored in the study: (1) differences in expectations, attitudes, needs, and satisfaction with the medical encounter between female and male patients, and (2) preferences of female and male patients regarding the gender of their physicians.

The literature review was conducted through computerized searches of Medline, Psychinfo, and Sociological Abstracts, manual searches of relevant journals and books, and cross-checking the bibliographies of previously published reviews and original publications.

2.1 Culture

Numerous definitions have been provided to the meaning of culture. Culture can be seen as consisting of everything that is human made (Herskovits 1955), or as involving shared meanings (Geertz 1973). According to Kessing (1974), culture must be studied within the social and ecological setting in which humans communicate. Helman (2001) suggested a broad definition, defining culture as a set of guidelines that individuals inherit as members of a particular society, that tell them how to view the world, how to experience it emotionally, and how to behave in it in relation to people, supernatural forces or gods, and to the natural environment. Culture is a schema shared by a large group of people, and it is their shared culture that influences interpersonal communication, not their membership in a society (Gudykunst 1988). Virtually all societies have more than one culture within their borders. Most societies have some form of social stratification into social classes and ranks, each marked by its own distinctive cultural attribute, and expected to conform to different norms and expectations. Each sub-culture develops from and shares many concepts and values from the larger culture, but also has unique features of its own (Helman 2001).

According to Spector (2000), the process of *acculturation* is involuntary in nature, the minority group member being forced to learn the new culture to survive. Acculturation may also be referred to as *assimilation*, the process by which an individual develops a new cultural

identity, becoming in all ways like the members of the dominant culture. *Heritage consistency* describes the degree to which a person's lifestyle reflects his or her respective traditional culture. A person can possess value characteristics of both a consistent heritage (traditional) and an inconsistent heritage (acculturated). A common assumption is that immigrants and ethnic groups are uniform in belief and behavioural norms. Such an assumption leads to simplistic ideas about ethnicity and stereotyping of cultural heritage. Religion, education, occupation, location, and gender, are social factors creating diversity within groups (Barker 1992).

Culture shock is associated with the mental and physical energy expended in adjusting to the changes and uncertainties of adapting to a new cultural group, whether ethnic, professional, organizational, local, national or international (Kim 1991), when values and beliefs upheld by the new culture are radically different from the person's native culture (Luckman 2000).

The following section discusses cultural variability and intercultural communication, and then surveys the findings on culture and health care.

2.1.1 Cultural variability

Various dimensions of cultural variability have been identified and investigated by researchers of different disciplines. Gudykunst (1988) claimed that while many of these schemas are useful, their relationship to communication processes has not been articulated. Gudykunst identified several schemas of cultural variability that influence communication more directly, are broader and more encompassing than other dimensions, and most widely used in research on interpersonal communication across cultures. Among them are the dimensions of *individualism-collectivism, universalism-particularism,* and *low- and high-context* communication.

The *individualism-collectivism* dimension has been isolated in anthropology, comparative sociology, cross-cultural psychology and philosophy, and has emerged in Western and Eastern analyses of culture (Parsons 1951, Kluckhohn 1960, Hofstede 1980, Triandis 1980, Hui 1986, Gudykunst 1988). Emphasis is placed on individuals' goals in individualistic cultures, while group goals have precedence over individuals' goals in collectivistic cultures. In individualistic cultures people are supposed to look after themselves and their immediate family; The "I" identity has precedence; emphasis is on individual's initiative and achievement; and people tend to apply the same value standards to all. In collectivistic cultures people belong to ingroups that are supposed to look after them in exchange for

loyalty; the "we" identity has precedence; emphasis is placed on belonging to groups; and people tend to apply different value standards for members of the ingroups and outgroups.

The pattern of *universalism-particularism* (Parsons 1951), is concerned with how individuals categorize people or objects. Universalism involves seeing the world through conceptualizations that are reflected in definitions of words, and does not take into consideration experiences that make individuals different, it is abstract. Particularism recognizes specifics, and tends to be associative, reflecting personal lives.

Hall's (1976) *low and high-context* schema focuses upon differences in communication processes that predominate in cultures. In a high-context communication or message, most of the information is either in the physical context or internalized in the person, while very little is in the coded, transmitted part of the message. In a low-context message, the mass of information is vested in the explicit code. Gudykunst (1988) argued that all cultures labelled by Hall as low-context are individualistic according to Hoftede's (1980) schema, and all cultures labelled as high-context are collectivistic. Low-context cultures like the US are characterized by a universalistic orientation, while a particularistic orientation tends to predominate in high-context cultures like those in the orient (Gudykunst 1988). See also Section 2.5.4: verbal communication styles.

2.1.2 Intercultural communication

According to Porter (1988), the relationship between culture and communication is reciprocal. Whatever individuals talk about, see, attend to or think about is influenced by their culture, and in turn helps shape, define, and perpetuate their culture. In intercultural communication, when the messages being interpreted are encoded in another culture, the cultural influences and experiences that produced the message may have been entirely different from those that are being drawn upon to decode the message. Consequently, unintentional errors in meaning may arise. Cultural variability also has a major effect upon norms, roles, language use, use of space, communication difficulties, and skills that facilitate effective communication (Argyle 1981, Gudykunst 1988). Professionals in a dominant culture who lack intercultural communication proficiency may tend to misperceive a minority or culturally different client (Sodowsky1991). Intercultural communication calls for relationship development that is sufficient to bridge intercultural gaps and produce desired results, such as effective management, friendship, and conflict resolution (Kreps 1994). The parties to intercultural communication must have an honest and sincere desire to communicate and seek mutual understanding (Porter 1988).

2.1.3 Culture and health care

2.1.3.1 Social and cultural aspects

The sub-culture of the medical profession reflects many of the social divisions and prejudices of wider society, which may interfere with health care and doctor-patient communication (Helman 2001). According to Loustaunan (1997), *ethnocentricism* involves using one's own standards, values and beliefs to make judgments about someone else. Ethnocentricism can be observed regarding the tenets of science and medicine, which may be considered natural or "correct", and therefore outside of cultural considerations (Pfifferling 1981). This *medicocentrism* focuses on disease, identified through signs and symptoms, and not on the patient or the patient's perception of a problem. Physicians, as products of their own cultures, of their medical training and of their occupational sub-culture, may exhibit both ethnocentric and medicocentric attitudes, which compound the problem of bias.

Ethnicity is tied to notions of shared origins and shared culture. An individual may have many ethnic identities, which may be used selectively shifting back and forth between identities (Loustaunan 1997). As different contexts call forth different dimensions of the self, a person may be exhibiting the self that is most pertinent in a given situation (Goffman 1959). Members of certain groups may have little input into the social system that governs them. This minority status reflects their lack of opportunity, access, and participation, which affect both health status and care (Loustaunan 1997).

Racism is the belief that members of one race are superior to those of other races (Spector 2000). Racial identities are typically constructed by an attempt to naturalize the difference between belongingness and otherness (Hall 1992). Racism in the medical encounter has been considered by several investigators (Kochman 1981, Lin 1983, Levy 1985). Emotions found to be engendered by racism are anger, resentment, distrust, paranoia, passivity, aggression, demoralization and despair, and negative self-image.

Culture affects perceptions and experiences of the meaning of illness, the visible signs of health, the treatment for health problems, and preventive measures (Loustaunan 1997). These factors influence such medically crucial concerns as proper diagnosis; recommendations of proper and achievable treatment; communication between patient-physician and family; treatment decision-making; use of services; willingness or ability to follow recommendations; patient and physician satisfaction; and health outcomes (O'Connor 1997). Different societies produce different types of medical systems, and different attitudes to health and illness,

depending on the dominant ideology, which have been investigated by a number of researchers (Wardwell 1972, Kleinman 1978a, Spector 2000, Plotnikoff 2000, Helman 2001).

2.1.3.2 Physicians' and patients' perspectives and relations

Physicians and patients, even if they come from the same social and cultural background, view ill health in very different ways. The medical profession can be seen as a healing sub-culture. Medicine is based on scientific rationality and directed towards discovering and quantifying physiochemical information about the patient. The medical definition of ill health is largely based on objectively demonstrable physical changes in the body's structure or function. The abnormal changes or diseases are seen as "entities", each with its own "personality", made up of a characteristic cause, clinical picture, results of investigations, natural history, prognosis and appropriate treatment. This perspective, however, does not include the social, cultural, and psychological dimensions of ill health and the context in which it appears, which determine the meaning of the disease for the individual patient. Both the meaning given to the symptoms and the emotional response are influenced by the patients' own background and personality as well as by the cultural, social and economic context in which they appeared, and will affect subsequent behaviour and treatment (Kleinman 1978b, Helman 2001).

According to Kleinman (1980), an "Explanatory Model" (EM) is a way of looking at how illness is patterned, interpreted and treated. Negotiation of Explanatory Models involves acknowledgment of differences in belief systems between patient and physician. If the patient does not seem to agree with the biomedical explanation, a compromise can often be reached by presenting the problem in terms and concepts that reflect the patient's EM (Carrillo 1999). This requires that the physician is sufficiently knowledgeable about his or her own culture, and about patients' other cultures, in order to recognize the differences; understand what they mean; and translate or bridge those differences to accomplish clear and effective communication and caring (Becker 1974, Helman 2001, Kagawa-Singer 2003). Developing effective multicultural relations between culturally unique participants in the modern health care system was found to be a prerequisite to effective health care delivery (Lin 1983, Wohl 1989, McNeil 1990). Luckman (2000) identified eight barriers to transcultural communication in the health care setting: lack of knowledge; fear and distrust; racism; bias and ethnocentrism; stereotyping; ritualistic behaviour; language barriers; conflicting perceptions and expectations. Barker (1992) noted that no matter how acculturated a person appears, at times of great stress such as illness or death, early-learned ideas resurface and structure responses.

Numerous studies in the US have considered the impact of racial and ethnic disparities in the health care system (Komaromy 1996, Gray 1997, Carlisle 1998, Saha 1999, 2000, Cooper-Patrick 1999, Laveist 2002). Laveist (2002) examined a US national sample of African-American, white, Hispanic, and Asian-American patients. In each race/ethnic group, patients who had a choice in the selection of a physician were more likely to be race-congruent, and race-congruent respondents reported greater satisfaction with their physician. Lin (1983) referred to the supposition termed as "cultural blind spot syndrome", which assumes that similarities in the ethnic background of physician-patient dyads enhance communication, arguing that this assumption is too simplistic; shared ethnicity alone is insufficient to ensure an effective interaction. Establishing a therapeutic alliance is built upon the match between the clinician's and the patient's EMs and therapeutic expectations. Ethnicity does not guarantee a physician's cultural awareness and sensitivity, either to members of his or her own ethnicity, or to those of other ethnic groups. Hufford (1997) claimed that what counts as being in the "best interests of patients" can vary from one cultural group to another, and among members of a single cultural group. Therefore, "best interests" cannot be determined without the involvement and approval of the patients themselves.

2.1.3.3 Patients' diverse cultural health attitudes, beliefs, expectations and needs

Some culture-related variables include attitudes toward health and illness; perceptions of causation of diseases; role of patient and physician; patient-physician interaction style; role of the family when a member is ill; patients' expectations, needs, and coping styles (Gordon 1990).

Culture-related differences in health care expectations and outcomes have been the focus of a large body of research (Gorkin 1986, Chae 1987, Wuest 1991, Schreiber 1991, Uba 1992, Ali 1993, Blackhall 1995, Murphy 1996, Butow 1997, Matthews 1998, Ehman 1999, Sheiner 1999, Collins 2000, van Ryn 2000). Patient ethnicity was associated with physicians' assessment of patient intelligence; feelings of affiliation toward the patient; and beliefs about patients' likelihood of high-risk behaviour and non-compliance. All these suggest that physicians apply general cultural or ethnic differences to their impressions of the individual patient (van Ryn 2000). Ethnic and cultural norms were found to influence patients' propensity to ask questions, express concerns, and be assertive during the interaction (Merkel 1984, Ashton 2003).

Asian concepts of health derive from the central concept of balance between individual, society, and the universe. Many South-East Asians see suffering and illness as part of life and may not seek medical care for many ailments (Uba 1992). Japanese emphasize respect,

politeness, and self-control, which may lead to avoidance of discussing symptoms and avoidance of disagreeing with health professional (Chae 1987). Family involvement in health and illness varies by culture. Hispanic-Americans are likely to view family as liaison between patient and physician. Korean-American and Mexican-Americans tended to hold a family-centred model of medical decision-making rather than the patient autonomy model favoured by most of the African-American and white patients (Murphy 1996, Blackhall 1995).

Religion strongly affects the way people interpret and respond to the signs and symptoms of illness (Spector 2000). Since all religions are concerned with the meaning of affliction, suffering, illness and healing, physicians should not ignore or overlook the patient's religion or spiritual understanding of the world, which are unfamiliar to the physician (Plotnikoff 2000).

A basic principle of the Egyptian culture is the belief in predestination. For the Muslims, being afflicted with a serious disease is predestined, and stoicism is expected. Egyptian researchers found that Christian cancer patients held the same cultural beliefs as Muslims regarding health, illness, treatment, and recovery. Egyptian patients comply with medical regimen vigorously, which mainly originates from the Quran's rules advising people to get the advantages of education, science, and technology. The patient cannot contradict or question the physician, this would imply impolite behaviour, or lack of respect (Ali 1993).

Several studies have investigated the cultural issues characterizing patients and physicians from the former Soviet Union (FSU) now living in Israel and in the US (Holden 1981, Firkowska-Mankiewicz 1991, Brod 1992, Bernstein 1994, Remennick 1997, 1998). Marginal immigrant status, poor proficiency of Hebrew, and confusion by the differences between the western host medical system and the socialist Soviet system were found to result in serious problems in the care of immigrants and in dissatisfaction (Remennick 1998).

Ethiopian immigrant patients in Israel have a unique set of problems. With increased acculturation, Ethiopian patients seemed to seek medical care for illnesses that they have learned are medically recognized, but not for complaints that do not fit into biomedical categories. They may have adjusted their expectations to fit local service provision, but their underlying views about the definition and causation of illness seemed to persist (Reiff 1999).

The culture of Orthodox Jews also has an impact upon health care issues (Donin 1972, Spero 1981, 1983, Larson 1992, Wieselberg 1992, Bilu 1992, 1994, Lowenthal 1993, Giglio 1993, Heilman 1994, Silverstein 1995). A "religiosity gap" between patients' and therapists' values may explain why many patients consult with clergy prior to seeking help from health care

professionals (Giglio 1993). Challenging patients' religious beliefs may cause the therapist to be neutralized or even disqualified, and may bring an abrupt termination of therapy (Spero 1981).

For a discussion of health information and cultural diversity, see Section 2.2.2.6. For more on decision-making and cultural diversity, see Section 2.3.5. For time and cultural diversity, see Section 2.6.5, for gender and cultural diversity, see Section 2.7.6, and for patient satisfaction and cultural diversity, see Section 2.8.2.

2.2 Information

This section reviews the topic of information giving and receiving in interpersonal communication, particularly medical information models and information in health care.

2.2.1 Medical information models

Kleinman (1980) proposed an "Explanatory Model" (EM) as a way of looking at how illness is patterned, interpreted and treated. Among laymen, EMs tend to be changeable and influenced by both personality and cultural factors, and are characterized by vagueness, multiplicity of meaning, frequent changes and diffuse boundaries between ideas and experience. Physicians' EMs are based mostly on causal scientific logic.

According to Helman (2001), the model of modern medicine is directed mainly towards discovering and quantifying physiochemical information about the patient, rather than to the less measurable psychosocial concerns of patients. Consultations between patient and physician are actually transactions between the layman's EM for a particular illness and that of the physician. Nevertheless, the transaction can only be fully understood in the context of the social and economic organization and dominant ideology or religion in which the individual became ill and the physician was consulted. When many people in a culture agree on a pattern of symptoms, origin, significance and treatment, the illness becomes an "illness entity" or "folk illness". This is more loosely defined than medical diseases and is greatly influenced by the socio-cultural context. Another way of looking at lay explanations of ill health is to examine the questions people ask themselves when they perceive themselves as being ill (Helman 1981).

Cassell (1976) distinguished between "illness" and "disease". Disease is associated with bodily organs, while illness is something the patient feels when he or she goes to the doctor. Explanations of ill health are often externalized in the form of a "narrative" or story about how and why the person became ill (Kleinman 1988). Medical healers, symbolic forms of

healing, and most religious traditions all help their clients reveal and shape their narratives. In western medicine, the physician seeks to organize the patient's "case history" into linear form, with a clear beginning for events, a sense of duration and ending at the present time. In traditional healing systems, the patient offers the healer only a small amount of information, and the healer does most of the talking. Thus, the sign of a good healer is someone who asks few questions and can quickly provide a diagnosis (Helman 2001).

2.2.2 Information in health care

Information in health care involves exchanges between physicians and patients, as well as formal and informal sources of information. The following discussion outlines models for these information exchanges.

2.2.2.1 Physician information gathering

The initial dialogue between physician and patient usually takes the form of an interview, with the patient seeking help and the physician seeking information to provide that help. Traditionally, health care practitioners have used the "directive interview" approach as their primary interview style to obtain specific information and to offer a course of action. Asking questions enables physicians to obtain a great deal of information, and also allows patients to tell their own stories. However, doctors were found to ask too many questions and not allow patients to tell their story; to ask questions that are too long or too complicated; to ask questions in a way that may bias the answers given; and to ignore questions that patients may ask (Tuckett 1984, Kreps 1992, Lloyd 2004).

In the "patient-centred interview", in contrast, the practitioner's role is to assist the patient in achieving insight and finding solutions to problems. Fisher (1984) has referred to human beings as "homo narrans", tellers of stories. By failing to encourage patients to tell their stories, physicians are potentially losing a wealth of health information that would help them provide more effective health care (Kreps 1992). Cassell (1985) said that medical history taking is often taught as if the object is to strip away all the confusion heaped on the facts by patients, yet when doctors discard all the patient's meanings, values and notions, they may have found the disease but discarded the patient.

The prevalence of yes/no questions, the selection of specifically medical topics of inquiry, and the determination of the scope of patient response through follow-up questions, were all found to limit patient initiative in the history-taking context (Mishler 1984, Roter 1992). Hampton (1975) confirmed the importance of gathering information about the patient's history in making a diagnosis. In 66 of 80 patients, the correct diagnosis was made based on

the patient's history alone, while only in seven patients was the initial diagnosis changed after physical examination, and in seven other patients it was changed after test results.

One problem in collecting patient data is that patients tend to express their concerns after the history has been taken. Barsky (1981) termed patients' late announcements of psychosocial concerns "hidden agendas". Beckman (1984) argued that the term "hidden agenda" focuses attention on the patient's decision to withhold or delay sharing relevant information, but ignores the physician's influence on the flow of information provided by the patient. Beckman recorded 74 office visits and reported that in only 17 (23%) visits was the patient provided the opportunity to complete the opening statement of concerns; in 51 (69%) of the visits, the physician interrupted the patients and directed questions towards a specific concern. Physicians did not permit patients to express a full range of concerns; after a brief period of time (mean 18 seconds), and often after the expression of a single stated concern, the physician took control of the visit by asking specific, close-ended questions, that halted the spontaneous flow of information from the patient. Once interrupted, only one of 52 patients went on to complete their statements.

Another issue involves the amount and scope of information patients give, sometimes volunteering more information than asked for. Some lifeworld narratives can be treated as resources for learning more about patients and ultimately facilitating their care and education. However, physicians must determine whether this information represents an issue which should be addressed, how it should be managed, or whether it should just be "filed away" as information (Beach 2001, Stiver 2001).

2.2.2.2 *Physician information-giving*

Based upon the information gathered from the patient, together with results of the physical examination and tests, the physician makes a diagnosis and devises a management plan to be explained and discussed with the patient. The manner in which information is presented to the patient has been shown to have a major effect on the level of patient anxiety and stress, the outcomes of medical procedures, satisfaction with care, and compliance with treatment (Lloyd 2004). The amount of information given by the physician depends on mutual and reciprocal expectations, perceptions, attitudes, and communication skills of the participants (Pendleton 1980). Tuckett (1984) discussed the notion of the medical consultation as a negotiated exchange of information that causes patients to comply with advice, helps patients to order and understand symptoms in terms of their cultural frameworks, and increases patient satisfaction.

A number of researchers considered the nature of the exchange of information between doctors and patients in the medical encounter (Street 1991, Waitzkin 1985, Billings 1989). Differences in physicians' informativeness were related to patients' communicative styles (question-asking, opinion-giving, expression of concern), and to patients' personal characteristics (age, gender, education, anxiety). The length of acquaintance between doctors and patients was associated with information transmittal; doctors who knew their patients for a longer period of time tended to give more information. Lee (2003) challenged commonly accepted practices of information transmission in health settings as insufficient because they are rooted in a one-way model of information transfer, which contributes to the hierarchical, one-side relationship assumed by health communication practices. A concept of information exchange is proposed, based on two-way dialogue that is more attentive to social relationships and contexts, ensuring that health information is not simply received, but also acted upon. A number of studies have supported this notion calling for more shared, patient-centred encounters that give patients more voice and involvement in their own health care (Roter 1989, Waitzkin 1991, Brown 1999, Charles 1999). Smith (1991) suggested integrating patient-and physician-centred approaches to interviewing; the patient leading in areas where he or she is the expert as on symptoms, concerns, preferences, and values, and the physician leading in the domain of expertise such as discussing details of organic disease and estimating probabilities of disease.

Patients were found to have more than one concern when visiting primary care physicians, including medical problems, requests for prescriptions, and information (Barsky 1981, White 1994, 1997). Patients' concerns usually get topicalized by physicians at the beginning of encounters (Beckman 1984,Bates 1995), however, these solicitations are treated by physicians as a single concern, and rather than continuing to solicit additional concerns, physicians progress through the activities of history taking, physical examination, diagnosis, and treatment (Beckman 1995, Marvel 1999). This has promoted the "by the way" syndrome, where patients present "doorknob" concerns (Byrne 1976, Zoppi 1997). Robinson (2001) claimed that physicians frequently design final-concern questions in ways that manipulate patients toward responses that do not raise additional concerns.

2.2.2.3 Patient information-seeking and question-asking

Patients use information in health care to self-monitor health conditions by gathering information through conscious and autonomic internal feedback mechanisms; to seek evaluation of health conditions from relevant others; to gather information from others about achieving and maintaining optimal levels of health; and to evaluate the adequacy of different health care activities and direct future behaviours. The traditional approach to physician-

patient relationships assigned expertise to the physician, and patients were dependent on the physician for all their information (Kreps 1990). Several researchers have considered this issue of the amount and nature of the information sought by patients in the medical interview (Beisecker 1990, Roberts 2000a, McIntosh 2003). Waitzkin (1984, 1985) emphasized that patients almost always want as much information as possible yet doctors often do not realize this, tend to underestimate patients' desire for information, and maintain a style of high control, which involves many doctor-initiated questions, interruptions, and neglect of patients' lifeworld. Faden (1981) claimed that it is unclear to which extent doctors and patients agree about information that should be disclosed. Although the need for specific information varied between patients, cancer patients in general wished to be well informed about their diagnosis, therapeutic options, and side-effects (Fallowfield 1990, 1993, 1994, Stigglbout 1997). Younger patients were found to conform to the well-informed participant standard of patient behaviour, while older patients were more likely to prefer the less informed, non-participatory patient role (Cassileth 1980). Patients who received a training book asked more direct, assertive, and clarifying questions than untrained patients. Training seemed to enhance more effective question forms, which were recognized as information-seeking attempts by physicians, who then addressed patients' concerns (Cegala 2000).

2.2.2.4 Patients' understanding of information

A high level of awareness and knowledge of health-related topics has obvious potential for increasingly productive and satisfying physician-patient relationships. Knowledge may lead to improved patient comprehension and more informed questioning, and can indirectly help patients in their efforts to establish rapport and credibility with caregivers (Ruben 1990). According to Kreps (1990), formal and informal health education communicates both content information (descriptive data about the nature of health and health care) and relationship information (level of concern, sensitivity, and power which health educators feel toward their audiences). Nevertheless, physicians' and patients' efforts to share relevant information are often deterred by miscommunications and misinterpretation of communicated information that are caused by a variety of reasons, such as the complexity of health-care problems, the urgency and emotionality of health-care situations, failures of understanding and memory, physicians' overuse of medical jargon, and lack of time (Ley 1967, 1983, Barlund 1976, Kreps 1984, 1988, Tuckett 1985, Billings 1989, Cromarty 1996, Quirt 1997, Cegala 2000). Cromarty (1996) challenged prior research, claiming it has chiefly examined the physician's conduct rather than the patient's viewpoint, and confirmed findings by Stimson (1975) and Tuckett (1985) of little dialogue and sharing of ideas between physicians and patients. Patients had a central desire to search for meaning in everything physicians said or did, and

were reluctant to ask questions. Many studies have suggested that patients often do not understand or recall physicians' explanations or instructions (Roter 1987, Grover 1994, Ong 1995, Logan 1996, Levinson 1999, O'Keefe 2001).

2.2.2.5 *Formal and informal health information*

Formal health education occurs when health-care specialists share relevant health information with health care consumers during office visits, and when providers write or distribute health information through the written and mass media, as well as via public health campaigns. Informal health education generally develops in two ways: (1) directed informal health education, involving messages offered in conversations in which health problem remedies are recommended, and (2) undirected informal health education, for example through the media, and as communicated in popular stories and legends, leading to culturally based health beliefs and folk remedies. Such informal communication networks are extremely powerful sources of health information because they are easily accessible, well utilized, and personally involving for most people (Kreps 1990). Several researchers have discussed the knowledge gap between physicians and patients, and the new informed patient (Ruben 1990, Hardey 1999, Lloyd 2004). Developments in information technology such as the Internet and the changing expectations of patients have come to challenge the notion that the physician is always the expert.

2.2.2.6 *Health information and cultural diversity*

Health care providers need to be aware of differing beliefs, values, attitudes, and world views that can influence perceptions of health and illness, and can serve as a powerful source of information and a potent tool for healing. Beliefs dictate which symptoms are considered appropriate to take to a doctor, how patients understand the cause and treatment of their illness, what patients expect of physicians, and what personal and moral meanings they ascribe to their illness (Kreps 1992). Martin (1983) identified the skills needed by an affective clinician to explore patients' beliefs: listening, identifying beliefs, and reframing those beliefs. Katz (2000) compared patients' self presentation and information transfer in conventional and unconventional medical interactions, claiming that the conventional setting leads to an asymmetrical doctor-patient relationship, limiting information transfer by the patient. In contrast, the orientation to equality and responsibility sharing in the unconventional setting promotes mutuality and information transfer between patient and practitioner.

Japanese cancer patients and physicians were found to differ in the category of question-asking. The percentage of physician question-asking was almost double that of patients', and the consultation was largely focused on biomedical topics. Compared to two studies in the UK and the Netherlands, the proportion of statements showing concern and reassurance was smaller, indicating that Japanese people tend not to express their emotions by direct verbal statements (Ishikawa 2002). Maly (2003) assessed differences in physician provision of information to white, African-American, and Latina older female cancer patients. Physicians discussed a number of topics less often with African-American and Latina patients compared to white patients, although minority patients considered discussions of most topics helpful, as did whites. Ethnic minority patients preferred information-giving through interpersonal health professional contact, rather than written information.

2.3 Decision-making

The discussion on decision-making (DM) focuses on five main issues: socio-cultural perspectives, participatory decision-making (PDM), patient preferences in PDM, patient satisfaction, and cultural diversity.

2.3.1 Socio-cultural perspectives

Socio-cultural theoretical perspectives have dealt with the impact of DM in the medical context. For *functionalist* theorists, power is a generalized social resource flowing through the political system, given by general consensus to those who have earned it through their contribution to society. Hence, medical dominance along with the authority held by the medical profession are viewed as the desirable method of maintaining social distance between doctor and patient. It allows the physician to take control and perform the healing function successfully, thus serving the best interests of the patient (Lupton 1994). According to Parsons' (1951, 1987) "sick role", a person afflicted with serious illness is physically disabled, and is forced to rely upon others, hence deviating from the expectations of social roles. The state of illness is such that patients have a psychological need to leave DM to the doctor's competence and judgment, in order to absolve themselves from any responsibility for the management of their illness (Mechanic 1979). The functionalist perspective has been criticized for its neglect of the potential for conflict inherent in the medical encounter. Critics argued that it typifies patients as compliant, passive and grateful, while doctors are represented as beneficent, competent and altruistic (Turner 1988).

The *political economy perspective*, informed by Marxist critiques of the nature of the capitalist economic system, views the ill, ageing or physically disabled as marginalized by

society, because they do not contribute to production and consumption of commodities. Like the functionalists, political economists see medicine as a moral exercise used to define normality, punish deviance and maintain social order. But they believe that this power is harmful and is abused by medical professionals (Freidson 1970, Waitzkin 1972, 1984b, Illich 1976, Starr 1982, Lupton 1994). Illich (1976) argued that modern medicine is both physically and socially harmful due to the impact of professional control over medicine. This leads to dependence upon medicine, obscuring the political conditions which cause ill health, and removing autonomy from individuals to control their own health. The political economy perspective has been criticized for ignoring the micro social aspects of the doctor-patient relationship, for representing it as the equivalent of the capitalist-worker relationship (Ehrenreich 1978), and for failing to recognize that the overall health status and access to health care of populations in socialist states have historically been worse than those of populations of capitalistic societies (Turner 1988).

The perspective of *social constructionism* examines the social aspects of biomedicine, focusing on the development of medico-scientific and lay medical knowledge and practices. Medical knowledge is regarded as a series of relative constructions that are dependent upon the socio-historical settings in which they occur and are constantly renegotiated. Thus, the approach allows alternative ways of thinking about the truth claims of biomedicine, showing them to be as much social products as lay knowledge of medicine (Lupton 1994). Foucault (1975) charted the emergence of a new "clinical gaze", a way of seeing the patient's body. This changed the vision from the speculatively based medicine of the 18th century, to the scientifically based medicine of the 19th. This notion of medical power extends the medical dominance expressed by the political economists, viewing power relations in the medical encounter as more subtle, enforced as much by individuals' unconscious self-surveillance as by authority figures. In understanding power relations as productive rather than coercive, the assertion of functionalism is restated, claiming that medical dominance is necessary for practitioners to take control in the medical encounter to fulfil the expectations of both parties, rather than being a source of oppression as argued by the political economists (Fisher 1991, Lupton 1994). This perspective has been criticized for making broad generalizations and avoiding examinations of the micro-context such as the everyday experiences of people; for the insistence that discourses have general social effects regardless of social class, gender or ethnicity; and for not recognizing human agency and the opportunity for resistance (Turner 1984, Shilling 1991).

For those who believe that the medical profession has too much power, a growing movement directed towards encouraging patient assertiveness is seen as a sign of a diminishing of

medical dominance. The growth of the *consumerism* ethos in the 1970s, together with an increasing corporatization of medicine, has made an impact upon the professional status of the medical practitioner (Lupton 1994). The medical consumer, as opposed to client, assumes more bargaining power in the relationship with the medical provider. The client comes to the professional for advice and accepts the professional's opinion, whereas the consumer listens to the thoughts of the provider, or of several providers, but ultimately makes his or her own decisions (Reeder 1972). The consumerism model of medicine has been elaborated by a number of researchers (Haug 1973, Gallagher 1976, McKinlay 1988, Neuberger 2000). Silverman (1987) and Lupton (1994) discussed the role of patient as consumer, arguing that although there is potential for people to resist the passive patient role, there are limits constraining the extent to which patients can do so, including health problems, social class, age, ethnicity and gender. It is therefore doubtful that the new breed of patient described in consumer guides, armed with medical knowledge and ready to challenge the doctor's authority, is in the majority.

The *Health Belief Model* (Rosenstock 1966, Becker 1974, 1975) hypothesizes that people seek and comply with health care regimes under certain specific conditions: belief in susceptibility to and severity of the disease; belief in the efficacy of treatment; self-efficacy; and perceptions of the cost of treatment. DiMatteo (1982) noted that development of the Health Belief Model has placed the physician in an excellent position to change patient beliefs and resulting attitudes by tailoring interventions to suit the particular needs of the individual patient. This kind of "objective" approach to health beliefs was criticized by Good (1994), claiming it carries the danger that patients' subjective opinions and accounts, which have no ground in objective medical reality, are taken to be unreal.

2.3.2 Participatory decision-making (PDM)

A major issue in medical DM is the participation of the patient. Billings (1989) argued that the purpose of the medical interview is not only to elicit information for diagnosis and treatment, and to educate patients about their illness and its management, but also to learn about patients' preferences and values. An appreciation of the patient's viewpoint helps the physician and patient negotiate mutually satisfactory clinical decision-informed choices that are consonant with the patient's wishes and the physician's medical advice. Billings described the clinical process of "informed consent" for making both critical and ordinary treatment decisions: (1) the patient is informed about the nature of the condition, and about reasonable options for diagnosis and treatment, including risks and benefits; (2) the physician's particular advice for the patient is explained; (3) the patient's preferences are elicited; (4) the physician seeks the patient's approval for a negotiated plan. Informed consent has become a medical-

legal requirement, particularly in hospitals. Deber (1994) noted an important distinction between the legal notion of informed consent and the ideal of shared DM. Informed consent does not mean that the patient is an active partner in care. Therefore, it cannot achieve the benefits of a model in which the patient is an informed partner who understands and sets treatment goals.

Researchers have discussed the notion of the clinical consultation as a transaction between lay and professional Explanatory Models (Kleinman 1980) or a negotiation between two parties separated by differences in power, both social and symbolic (Stimson 1975, Helman 2001). Stimson (1975), Lazare (1978), and DiMatteo (1982) pointed out that there is often a conflict between physician and patient that may centre in issues such as the definition of the problem, the cause of the illness, the goals of treatment, and the priorities of treatment. Conflict and negotiation may also take place over completely intangible issues such as self-esteem, honour, and saving face. The asymmetry of power in the consultation was discussed by Silverman (1987), Gwyn (1999), and Katz (2002), suggesting that patients accept the discourse strategies that dominate doctor-patient interviews because they are seen as an implicit part of "the treatment". By questioning the authoritative voice of medicine they might be seen to be symbolically challenging the status quo of medical knowledge, thereby causing damage to their chances of recovery.

Helman (2001) emphasized that patients strive for diagnoses and treatments that make sense to them in terms of their lay view of ill health. A number of recurring problems were identified that interfere with the development of consensus: focusing on the individual patient while ignoring wider familial, social and economic issues; misinterpretation of patients' languages of distress when doctor and patient come from different cultural, socio-economic, or religious backgrounds; different age groups or gender.

A large number of researchers addressed the emergent interest among both physicians and patients in developing and advocating new approaches to treatment DM, which would incorporate a greater role for patients (Brody 1980, Quill 1983, Eddy 1990, Hughes 1991, Emanuel 1992, Cahill 1996, Charles 1997). Ballard-Reisch (1990) argued that the characteristics of communication in the health provider-health consumer relationship are changing as a result of a growing trend in health care away from the traditional paternalistic model and toward a process of PDM. A three phase PDM model is suggested: (1) diagnostic- which involves exploring the nature of the patient's condition, and the characteristics which affect the patient's ability to deal with the condition; (2) exploration of treatment alternatives- which involves the generation of possible alternatives, the establishment of criteria for an effective decision, and the process of weighing alternatives against criteria established;

(3) treatment decision, implementation and evaluation- which involves the selection of treatment protocol, the implementation of the treatment regime, and the evaluation of the effectiveness of treatment. This requires clear understanding and communication on part of both patient and physician. These phases were considered in detail by a number of investigators (Slack 1977, Fisher 1983, Robinson 1985, Weston 1989, Ballard-Reisch 1990, 1993).

Marinker (1997) suggested the concept of concordance that is based on the idea that health care practitioners and patients should work towards a mutual understanding about medicine taking and the development of a therapeutic alliance. A fundamental requirement to the concept of concordance is the open exchange of beliefs about medicines upon which both prescribing and medicine-taking decisions may then be based. Thus, concordance seeks to make patient participation explicit, and to make apparent potential areas of disagreement and conflict. Britten (2001) argued that the significance of the concept is that it acknowledges patients' autonomy and the potential conflict between physician and patient. Stevenson (2005) emphasized that concordance contains the principle of equality in terms of exchange of information, insofar as all parties have some relevant information to impart in relation to preferences about treatment options.

Charles (1997, 1999, 2003) developed a conceptual framework to identify, describe and differentiate the defining characteristics of current DM approaches: (1) paternalistic- characterized by physician control, one-way information exchange, and no patient input other than informed consent; (2) pure informed- characterized by a division of labour, and the preservation of patient autonomy. A well informed patient is assumed to make the best decision without need of physician input; (3) pure shared- characterized by simultaneous interaction by both physician and patient in all stages of the DM process, and two-way information exchange. The shared treatment decision-making (STDM) model was examined in a study exploring the expectations and perceptions of British patients prior to consulting a general practitioner (GP). Despite the advocacy of the use of patient-centred strategies, STDM did not seem to happen in practice. Potential barriers to STDM were identified: pressure of time; medical training in Britain that is mostly hospital based, was thought to encourage paternalistic practice, and to present a barrier to developing the requisite skills; the increased emphasis on opportunistic health screening in general practice was felt to interrupt the natural flow of consultations, and make it more difficult to engage in STDM; and GPs questioned patients' ability to understand medical language and problems as a barrier to participation (Stevenson 2000).

Schneider (1998) Gwyn (1999), Parascandola (2002), and Meyers (2004) addressed cases of medical uncertainty or medical knowledge that is complex and difficult to communicate, which represent a disproportionate burden for patients as barriers to participation.

2.3.3 Patient preferences for participation in decision-making

A major issue in medical PDM is the attitude of the patient toward his or her own role. Deber (1994, 1996) argued that studies have not clearly defined "participation", failing to differentiate between "problem solving" and "decision making". Patients overwhelmingly wanted problem-solving (PS) to be performed by or shared with the physician, but wanted to be involved in DM. These results suggested two major roles for physicians: assisting patients in PS by structuring choices, and supporting them in making often difficult decisions.

Patient preference was studied by Strull (1984), Larsson (1989) and Beisecker (1990). While patients definitely wanted information in each of a wide variety of medical areas, the majority of patients did not wish to assume the responsibility to make medical decisions, and perceived medical DM authority to rest more with physicians than with patients. Patients who rated their physicians as providing more information and involving them more in DM had better self-reported understanding of their diabetes self-care (Heisler 2002).

Several researchers have studied the DM preferences of women with breast cancer. Agreement between cancer patients and physicians with respect to DM preferences occurred only in 38% of cases reported by Bruera (2001). Asking patients for their input about treatment choices was the one physician communication behaviour that was positively associated with patient PDM (Maly 2004b). Degner (1992) and Stiggelbout (1997) attempted to determine what roles people actually want to assume in selecting cancer treatment. Their findings suggested that the impact of being diagnosed with a life-threatening illness may negatively influence the desire for PDM as compared to patients with non-malignant conditions, and patients' companions.

PDM facilitation was associated with female gender, non-white race, higher education level, younger age, lengths of visit, length of tenure with particular physician, chronic illness visits, highly complex decisions, and referrals to another physician. PDM facilitated visits took longer than non-facilitated visits (Cassileth 1980, Beisecker 1988, Gotler 2000, Adams 2001).

Brock (1990) discussed the implications of shared DM on physicians' responsibilities when competent patients make choices that appear to be irrational. The paternalistic approach often takes the patient's general preferences and attitudes toward treatment into account, yet gives patients only a minimal role in making decisions. In shared decision-making, selecting the

best treatment for a particular patient requires the active and essential contributions of both physicians and patients. It is unwarranted to conclude that proper respect for patient autonomy and self-determination means accepting patient treatment preferences no matter how they are arrived at. This fails to recognize tradeoffs between conflicting values involved in respecting or seeking to change patients' choices. Patient well-being can require the physician to attempt to protect patients from harmful consequences, potentially clashing with the right of patients to make decisions about their own lives. When a physician judges a patient's treatment choice as irrational, non-coercive and non-manipulative attempts to change that choice are common and proper and do not violate patients' rights of self-determination. However, distinguishing irrational preferences from those that simply express different attitudes, values, and beliefs can be difficult in both theory and practice (Kassirer 1983).

2.3.4 Decision-making and patient satisfaction

Patient satisfaction with medical care was reported to be affected by patients' and physicians' attitudes toward DM (Roter 1991a, Hall 1994a, Kaplan 1995, 1996, Turner 1996, Adams 2001, Street 2002). PDM style was found to be a reliable indicator of interpersonal care quality, as supported by its positive association with patient satisfaction and its negative relation to provider loyalty. For physicians, lower practice volume, previous interviewing skills training, satisfaction with personal autonomy, white race, and female gender were all associated with higher PDM style ratings.

2.3.5 Decision-making and cultural diversity

Cultural differences in DM may result in conflict or misunderstanding, when non-Western patients are asked to make independent health care decisions. In many cases, the patient's dilemma goes unnoticed, and the patient who has difficulties making decisions is labelled as "non-compliant". Patients from collectivistic cultures may abdicate DM to the physician, who is seen as a wise and benevolent authority figure. This approach does not allow for individual choice. Rather, physicians are expected to make decisions that are in the best interest of the greatest number of people involved with the patient. Patients may be less willing to share bad news within the group, because it may disrupt the harmony of the group. They may be less likely to question the decisions may by the family, because the decision was made for the overall good of the family. Families may be less inclined to question decisions made by physicians, who have to maintain the harmony of the health system (McLaughlin 1998).

Japanese physicians and patients relied more on family and physician authority, and placed less emphasis on patient autonomy than US physicians and patient (Ruhnke 2000). Doctors in Singapore, who are exposed to Western ethical concepts, were found to allow patients some say in DM, and keep patients reasonably informed. However, some inconsistencies were found between values and practices: they still lack openness in telling patients the whole truth; many doctors believe that a number of their patients are incapable of rational choices; and when patients refuse treatment, many doctors are prepared to involve family members in search for consensus, tempering the respect for patients' choices (Chan 2000).

Minority patients (African-American, Asian-American, Pacific Islanders, and American Indians) reported less participatory visits than non-minority patients (Kaplan 1995). Korean-American and Mexican-American patients were least likely to favour truth telling about diagnosis and prognosis, and least likely to choose the patient as primary decision maker about the use of life support as compared to whites. In the Mexican-American group, more acculturated patients were more likely to share the patient autonomy model with white and African-American patients (Blackhall 1995). African-American and Latina patients, and patients from low-income families, indicated a strong desire for information and participation in DM (McKeown 2002). McKeown warned that physicians should not assume that patients from disadvantaged populations do not want to play a substantial role in DM concerning their health care, and should probe for the levels of control desired by patients from similar populations.

African-American and Latina breast cancer patients were less likely than white patients to perceive themselves as the chief treatment decision-makers. However, ethnic minority women were more likely to question their surgeons about their treatment, possibly due to mistrust of the health care system (May 2003, 2004a).

2.4 Physician's interpersonal communication

This section reviews the literature on physician's interpersonal communication, focusing on three main issues: physician-patient communication, impact of physician communication on the patient, and patient satisfaction with physician communication. In the communication process, many components interact simultaneously: the messages to which people react; the meanings people actively create; the time and place of the communication (context); the relationships established between communicators; past experiences; people's personalities and dispositions; the purposes for communicating; the effects of communication on people and situations (Kreps 1992).

2.4.1 Physician's interpersonal communication characteristics

Among the important factors in physician's interpersonal communication are the patients' lifeworld, the therapeutic nature of communication, the role of empathy, and the use of humour and laughter.

2.4.1.1 The voice of lifeworld

Personal communication tends to be a humanizing form of human interaction, which treats the other person with respect, as an equal, and generally communicates in an honest and trustworthy manner. Objective communication tends to be dehumanizing, is insensitive and demonstrates lack of respect for the other person, without seeking his or her input on the matter (Kreps 1992). Habermas' (1984) theory of communicative action posits a dialectical struggle between two types of rationality that produce two different types of world: communicative or value rationality- which inhabits the lifeworld; purposive rationality- which inhabits the system. Habermas saw the dangers of the growth of the system as threatening to engulf the lifeworld, and called this System Rationalization. To regain a balance and push back the advances of system rationalization requires work towards communicative rationality via ideal speech interaction; reaching mutual understanding through harmonization and negotiation of definitions of situations without the use of coercion and power.

Mishler (1984) applied the concept of the lifeworld proposed by Habermas (1984) to the world of medicine. In dealing with patients, science-based medicine operates on some hidden assumptions that can be seen as distortions of the lifeworld. One such assumption is the power of doctors to dominate interactions and control communication, thus suppressing the coherent and meaningful accounts of patients. Barry (2001) identified four communication patterns found in general practice, classified according to use of the voice of lifeworld by doctor and/or patient: (1) strictly medicine- when doctor and patient both use the voice of medicine exclusively, this works for simple unitary problems; (2) mutual lifeworld- when both doctor and patient engage with the lifeworld, more of the agenda is voiced, and patients are recognized as unique human beings; (3) lifeworld ignored- where patients use mostly the voice of lifeworld but are ignored; (4) lifeworld blocked- where doctors immediately block glimpses of lifeworld by use of voice of medicine. Barry's results support the premise that increased use of the lifeworld makes for better outcomes and more humane treatment of patients.

Traditionally, medical practitioners have sought to avoid the milieu of emotion through their long-held advocacy of the scientific practitioner model, and their non-emotional approach to

the physician-patient relationship (Roter 1992). However, attitudes and beliefs about the role of emotions are changing in contemporary medicine, with research exploring the personal socio-emotional communication styles of physician (DeCoster 1997, Gulbrandsen 1997, Johanson 1996, 1998). Communication about lifestyle of Swedish primary care patients was a vital component in the consultations, which took up one third of the total dialogue, and was shared equally between physicians and patients. However lifestyle issues were explored for different purposes; patients talked about lifestyle to articulate themselves as individuals, while physicians used it as a resource to contextualize medical knowledge (Johanson 1996).

2.4.1.2 Therapeutic communication

Interpersonal relationships in health care can serve to increase or decrease the overall state of health (Kreps 1992). In turning to a physician, patients seek solutions for their illness as well as for their anxiety. Emotional support not only bridges over patient uncertainty regarding the content and outcome of the treatment, but is also a crucial element in patients' evaluation of the treatment itself (Ben-Sira 1980). Therapeutic communication is accomplished by formally designated therapists exchanging information with patients to help them prolong their live (Fuller 1973). Pettegrew (1977) has broadened this approach and defined it as communication transactions between helper and helpee resulting in: feelings of psychological (thoughts), emotional (feelings), and or physical (actions) relief by the helpee. Truax (1967) identified three key characteristics of therapeutic communication: accurate empathy and understanding; non-possessive warmth and respect; genuineness and authenticity. Suchman (1988) claimed that therapeutic contact takes place within a connexional (a mutual experience of joining that results in a sensation of wholeness) or transpersonal (going beyond the boundaries of one's "self" to join with an "other") dimensions of human experience, within which basic human needs for connection and meaning are met. Kreps (1992) indicated the importance of empathy, trust, honesty, validation, and caring in communicating therapeutically.

2.4.1.3 Empathic interaction

Empathic doctor-patient relations involve eliciting feelings; paraphrasing and reflecting; using silence; listening to what the patient is saying or is unable to say; encouraging the patient; as well as non-verbal behaviour (DiMatteo 1980, Comstock 1982, Risko 1992). A number of studies have considered the role of empathy in the medical encounter (Bellet 1991, Branch 1993, Gianakos 1996, Suchman 1997). Empathy is not synonymous with the tenderness, affection, or caring physicians show to patients, but refers specifically to the ability of physicians to imagine that they are the patient who has come for help (Gianakos 1996). Branch (1993) observed "windows of opportunity"- instances during which patients discussed

their concerns about personal, emotional, and family issues, which stood out from the rest of the interview. All began with an open-ended question. As the patient began to talk, the physician recognized emotion in the patient's voice and posture and allowed a transition in the interview, which satisfied patients and increased their trust.

Kreps (1992) emphasized the importance of listening in interactions. Accurate communication is a give-and take situation, where listening is defined as *giving* of oneself and talking as *taking* from others. Busy physicians are at a great risk of falling into poor listening behaviours, which can lead to serious misunderstandings and problems. Reflective feedback, silence when patients speak, body positioning and eye contact are listening skills recommended for effective communication (Gorney 1999). Australian GPs received ALM (Active Listening Module) medical training intervention that involved teaching the skills of hearing, processing and reflectively summarizing, and the attitude of empathy. Patient ratings of interpersonal skills were reported higher for GPs who participated in the ALM intervention (Greco 1998).

Billings (1989) argued that in every day medical work, the physician's words and behaviour convey and elicit meanings, emotions, and values not to be found in technologies alone. Numerous studies have considered interaction styles between patient and practitioner (Korsch 1972, Ben-Sira 1976, DiMatteo 1979, Like 1987, Carmel 1996, DeCoster 1997, Hall 1993, 2002b). Buller (1987) identified two general styles displayed by physicians: (1) affiliation- is composed of communication behaviours designed to establish and maintain a positive relationship, such as interest, friendliness, empathy, warmth, genuineness, honesty, compassion, a desire to help, a non-judgemental attitude, humour, and a social orientation. (2) Control- includes behaviours that establish and maintain physician's power, authority, status, and professional distance. Physician who adopted a more affiliative style received more favourable patient evaluations (Korsch 1968, 1972, Freemon 1971, Buller 1987, Barry 2001, Zachariae 2003).

Like (1987) found positive associations between how much the physician liked the patient, and both the physician's and patient's satisfaction with the encounter. Physicians had elevated liking for healthier and male patients, and female physicians were found to like their patients more than male physicians (Hall 1993). How much each liked the other was related to how much each was liked, thus demonstrating reciprocity. This suggests that a more liked patient might express more positive affect and cooperation, which in turn might increase further the physician's liking of that patient (Hall 2002b).

2.4.1.4 Humour and laughter

The role of humour and laughter has been studied by a number of researchers (West 1984, Jefferson 1987, Sacks 1992, Adams 1998, Haakanaa 2001, 2002, Purtilo 2002,). A subtle, often effective way of dealing with problems or hiding fears is through the use of humour. Used wisely, shared humour and laughter may help patients cope with stress related to illness and accompanying problems; defuse anxiety in tense situations; and open up connections between physician and patient. Joking can be used constructively to allow the patient to express hostility and anxiety; permit exploration of the humour and irony in the patient's condition; and reduce tension. Patients may use jokes about themselves in extreme openness, as one means of expressing very difficult thoughts and emotions. Some hospitals have humour carts, juggling equipment, and clowns visiting children's hospitals on a regular basis to bring joy and assist with patient care.

Patients in Finland used laughter to deal with delicate aspects of the interaction, in places where they had to momentarily portray themselves in an unfavourable light. By laughing, they displayed awareness of the possible delicacy of a situation, thereby also re-projecting a picture of a reasonable patient who knows what is problematic within an occasion. In giving of the reason for the visit, laughter occurred with reasons that were "extraordinary", somehow unlikely or incredible, and needed a special kind of framing, thereby dealing with the issue of the doctorability of the patients' problem (Haakanaa 2001, 2002).

2.4.2 Impact of physician's interpersonal communication style

Kleinman (1978) pointed out the importance of understanding patients' EMs as part of successful diagnosis and treatment, especially as those models are usually influenced by social or cultural factors. Physicians should elicit patients' EMs, and then compare these with their own models and their assumptions about the patient's model. This may reveal evidence of "typifications" or stereotyping that may be barriers to successful communication (Helman 1985).

The interpersonal communication in the physician-patient relationship has been studied by a number of researchers (Helman 1985, Leopold 1996, Brown 1995, Ogden 2002). Patient centeredness is currently regarded as the preferred style of physician-patient communication (Levenstein 1986, Stewart 1995). Ogden (2002) claimed that research has raised questions concerning both the definition of patient centeredness and its assessment, which has resulted in a range of methodological approaches to code whether a particular doctor is behaving in a patient-centred style (Stiles 1978, Henbest 1990, Winefield 1996, Roter 1997). In addition,

research studies have used a wide range of different but related terms such as shared DM (Gafni 1998, Elwyne 1999), patient participation (Guadagnoli 1998), and patient partnership (Coulter 1999). Although varying in the operationalisation of patient centeredness, Ogden (2002) identified a general construct that is considered to consist of three central components: (1) receptiveness by the physician to patient's opinions and expectations, and an effort to see the illness through the patient's eyes; (2) patient involvement in DM and planning of treatment; (3) attention to the affective content of the consultation in terms of both patient's and physician's emotions. Some researchers also included information-giving in patient centeredness (DeMonchy 1998, Grol 1990).

Primary care patients showed strong preference for a patient-centred approach with communication, partnership, and health promotion. This desire was greater than for biomedical aspects such as examinations or prescriptions (Little 2001). Patient-centred communication was correlated with patients' perceptions of finding common ground achieved with physicians; better recovery from discomfort and concern; better emotional health; and fewer diagnostic tests and referrals (Stewart 2000).

Ben-Sira (1976, 1980) used social interaction theory to describe the physician-patient encounter. When patients seek treatment for the illness, physicians address this goal through task behaviours such as prescribing medication. When patients seek the relief of anxiety, physicians use socio-emotional behaviours such as expressions of concern and reassurance. Patients must be able to recognize physicians' task and socio-emotional behaviours as either treating illness or relieving anxiety. Socio-emotional behaviours are easy for patients to identify and understand. By contrast, it may be difficult for patients, especially when anxious, to recognize and understand the association between physician's task behaviour and the treatment of illness, suggesting that patients respond to physicians mostly on physicians' socio-emotional behaviour. Roberts (2000b) found support for this proposition, although a mostly African-American sample of this study is not representative of the larger patient population. Physicians' socio-emotional behaviour was clearly recognized by patients and affected their trust, self-disclosure, satisfaction, and recall. Although patients recognized the physician's task behaviour, it did not affect their response. Dissatisfaction with socio-emotional behaviour appears to be a common reason for changing physicians, suggesting that patients rely heavily on this physician behaviour (Ware 1983, Marquis 1983, Gandhi 1997).

Fairhurst (2001) argued that the thrust toward patient-centred medicine, negotiative consultation skills, and the biopsychosocial model in primary care medicine all rely on the expectation that GPs can 'know' their patients. Two ways are identified of "knowing" the patient: a deductive mode of reasoning- derived from facts about the patient, specific to the

context of the consultation, leading to biomedical and biographical knowledge; an inductive mode of reasoning- derived from a contextual interpretation of facts, resulting in knowledge of patients' behaviour and cognitions, permitting the doctor to act in partnership with the patient to individualize the therapeutic intervention.

The outcomes of the medical encounter were found to be positively influenced by a physician who is friendly, engages in some general or non-medical conversation, and offers information freely without patient request (Freemon 1971). The quality of communication both in the history-taking segment of the visit and during discussion of the management plan was found to influence patient health outcomes (Stewart 1995). A review by Di Blasi (2001) assessed types of non-treatment care given by physicians, categorized as cognitive or emotional. Combination of emotional and cognitive care produced the most consistent positive effect on health outcomes. Primary care physicians' comprehensive knowledge of patients ("whole person") and patients' trust in their physician were strongly associated with three outcomes: adherence to physician's advice, patient satisfaction, and improved health status (Safran 1998).

Problems or conflicts in the doctor-patient relationship have been examined in a number of studies (Owen 1991, Joos 1993, Annandale 1998, Jain 1999, Bell 2001, Keating 2002). Daniel (1999) examined the experience of health care complainants: 64% of complaints were about clinical care; 22% were related to rudeness or poor communication; and 14% to unethical or improper behaviour. Taylot (2002) related emergency department patients' complaints in Australia to patient treatment, including inadequate treatment and diagnosis (33.4%); and to physicians' communication, including poor staff attitude, discourtesy and rudeness (31.6%). Kreps (1993) summarized research addressing specific recurring problems linked to interpersonal communication inadequacies, including low levels of patient compliance; insensitivity; miscommunication and misinformation; unrealistic and unfulfilled patient expectations; and dissatisfaction by providers and consumers. All these suggest that the effectiveness of communicative relationships directly influence the success of health care (Greenfield 1985, Kreps 1988). Waitzkin (1994) dealt with the social problems that older patients bring to the encounter. Many older patients consult practitioners who feel that the social context is not relevant to the medical task, or that their ability to grapple with contextual problems is limited. When such issues do arise, the structure of discourse tends to cut off, interrupt, and ultimately marginalize the discussion, even though these concerns may create substantial day-to-day distress.

2.4.3 Patient satisfaction with physician's interpersonal communication

Patient satisfaction was found to be related to several communication characteristics of physicians: discovering and dealing with patients' concerns and expectations; communicating warmth, interest and concern; volunteering a lot of information in terms that are understood by patients (Pendleton1983); clarity of communication about the medical condition and treatment; a collaborative and less directive interviewing style; patients' specific expectations for informative and effective care (Lochman 1983). Hall's (1988) meta-analysis related patient satisfaction to several factors, including the amount of information given by physicians; greater technical and interpersonal competence; more partnership building; more social conversation; more positive and less negative talk; and more communication overall. Roter (1989) identified six categories related to increased satisfaction: social conversation; conversation that could be construed as partnership-building; positive non-verbal behaviour; positive talk; technical and interpersonal competence.

Provision of information by doctors has been found to be positively related to patient satisfaction (Freemon 1971, Cornstock 1982, Roter 1989, Williams 1991b), specifically during the examination segment of the visit (Roter 1977, Wolf 1978, Stiles 1978, 1979a, 1979b). In contrast, a negative relationship was reported between patient satisfaction and time spent on patient history taking (Freemon 1971, Robbins 1993).

Numerous studies have considered patient satisfaction with physicians' interpersonal communication styles (Ware 1975a, Korsch 1981, Linder-Pelz 1985, Buller 1987, Hall 1988, Bertakis 1991, Emanuel 1992, Robbins 1993, Kaplan 1995, Laine 1996). Donabedian (1980) divided the activities of the management of illness into two domains: technical care- defined as the application of the science and technology of medicine to the management of a personal health problem; interpersonal care- involving the social-psychological aspects of the physician-patient interaction. Patients who indicated they received any one of the three non-technical interventions: education, stress counselling, and negotiation, were significantly more satisfied than those who had not received these interventions (Brody 1989). The psychosocial pattern of primary care physicians was associated with the highest patient satisfaction ratings, particularly in relation to a sense of partnership and support (Roter 1997). Ben-Sira (1980) examined Israeli patients' reactions to medical care, with regard to physician's skills, behaviour and emotional involvement. A lack of emotional involvement and support by physicians lessened patients' confidence in treatment and in the physicians themselves. Tension expressed in the tone of doctors and/or patients was negatively related to satisfaction (Carter 1982, Inui 1982).

Several researchers have focused on the relation between patient satisfaction and physicians' friendliness or personal attitude (Korsch 1972, DiMatteo 1980, Cleary 1988). Patients were most satisfied by interviews that encouraged them to talk about psychosocial issues, rather than about biomedical topics, in an atmosphere that was characterized by interest and friendliness, and the absence of physician domination (Bertakis 1991). Physician empathy and compassion was also considered in a number of studies (Thornett 2001, Deveugele 2002, Mercer 2002b, 2004). Carmel (1996) examined groups of Israeli physicians, who differed in their compassionate-empathic pattern of behaviour toward patients. The physicians identified as compassionate-empathic were younger, had fewer years in medical practice, scored higher on pro-social, non-stereotypic attitudes toward patients, and on empathy measures. All participating physicians considered empathic behaviour as the most important quality for being "a good physician". Patients viewed time, empathy, and the ongoing therapeutic relationship as areas of key importance (Mercer 2004). Cancer patients in Denmark associated physician attentiveness and empathy with greater satisfaction, increased self-efficacy, and reduced emotional distress following the consultation (Zachariae 2003).

2.5 Verbal communication

This section focuses on four main issues discussed in the literature on verbal communication in the medical encounter: (1) language and language barriers, (2) interpreter use and interpretation methods, (3) use of medical terminology, and (4) verbal communication style.

2.5.1 Language and language barriers

Individuals communicate, convey and receive messages through language. Nevertheless, such communication also involves both cultural and linguistic barriers (Brickley 1988). The Sapir-Whorf hypothesis suggests that beyond its role as a communicative technique, language itself directs the perceptions of its speakers, and provides for them habitual modes of analyzing experience into significant categories (Hoijer 1988). Several researchers and studies have pointed out that language differences can constitute significant and formidable barriers to cross-cultural communication and understanding, particularly in the health care field (Hoijer 1988, Kreps 1992, Gropper 1996). Others have argued that communication between physicians and patients is difficult even when they have a common language, dialect, and culture (Kaplan 1989, Baker 1996,). Loss of information from patients may disrupt how physicians assess and evaluate symptoms and result in misdiagnoses or in ordering unnecessary diagnostic tests. Poor communication between physician and patient may lead to incomplete patient education, misunderstanding of instructions, reduced compliance with treatment and follow up, and patient dissatisfaction. Therefore, particular care should be taken

to ensure genuine agreement between physicians, patients and patient-families about terms used for symptoms and diseases.

A large body of research on language barriers in medical communication has focused on the Hispanic community in the United States (Manson 1988, Kirkman 1991, Todd 1993, Woloshin 1995, Blackhall 1995, Baker 1996, Perez-Stable 1997, 2000, David 1998, Hampers 1999). Moreover, numerous studies have indicated that treatment by language-concordant physicians is associated with improved well being and functioning, more question-asking and greater recall of recommendations (Manson 1988, Seijo 1991, Todd 1993, Perez-Stable 1997).

2.5.2 Interpreter use and interpretation methods

The links between language, culture and thought raise difficulties for translators, who cannot just substitute one word for another but rather must translate whole contexts. Interpreting involves a good command of both languages, yet a good interpreter is more than a translator of words. A number of researchers point to the impact of culture on interpreting, particularly in the medical setting (Samovar 1981, Berris 1988, Loustaunan 1997). The interpreter is in a position of considerable power, and it is difficult for interpreters to remain entirely neutral. As sole possessor and processor of clients' views and questions, the interpreter is in a position to manipulate the information exchange as well as the situation. The physician-patient discourse is a dynamic process of constant shifting of emphasis between information gathering, problem solving, therapy, and education, to which the interpreter must adapt. The presence of the interpreter may change the dynamics of the interview, and can make a patient more inhibited about interrupting or questioning (Putsch 1985). Hence, simply finding someone who speaks the same language as the client is not sufficient; the interpreter must be perceived as encouraging and non-threatening to the patient (Fuller 1988, Crawford 1999, Davidson 2001).

Several studies addressed the length of interpreted encounters. Tocher (1999) found that the actual length of a visit did not differ between English-speaking and non English-speaking patients, yet 90% of physicians perceived that they needed more time with non English-speaking patients. Interpreted interactions did not take significantly longer than same-language interactions. The interpreter was found to act not as a neutral agent, nor as an advocate of the patients, but rather acted in tacit coordination with the physician as an additional gatekeeper who keeps the interview "on track" and the physician on schedule, a second institutional agent within the medical interview (Davidson 2000, Davidson 2001). Rivadeneyra (2000) claimed that patient-centred medical interviews are associated with greater patient satisfaction and better medical outcomes than traditional encounters, but

expressed concern about encounters with Spanish-speaking patients that required an interpreter. Due to the time consumed by the interpretation process, physicians concentrated on critical information rather than on patients' views, expectations, thoughts and feelings.

In some healthcare settings, paid translators are on call, while in others, cross-cultural advocates are available to interpret and educate health workers about their cultures (Fuller 1988). A survey of hospital interpreters in the US indicates that most hospitals do not have salaried professional interpreters routinely available, even when a substantial number of patients are not fluent in English (Woloshin 1995). To cope with this situation, clinicians rely heavily on untrained interpretation by family members, hospital staff, and other ad hoc interpreters. This practice results in frequent errors in translation, including omissions, additions, substitutions, and condensation of what was said by both clinician and patient (Putsch 1985, Baker 1996).

A number of studies have focused on the specific problems of using relatives as interpreters. The criticisms range from lack of familiarity with medical terms to a reluctance to reveal intimate details in the presence of family and friends to the issue of interpreters who respond instead of the patient (Fuller 1988, Ebden 1988, Phelan 1995, Baker 1998, Dwyer 2001, Ngo-Metzger 2003). Many researchers have also warned against using children for interpreting in medical interviews (Woloshin 1995, Jones 1998, Cohen 1999, Dwyer 2001, Ngo-Metzger 2003). Children lack the emotional and cognitive maturity to assume responsibility for interpreting conversations between parents and professionals, and the normal order of the family may be disturbed. Rack (1982) emphasized a universal unsuitability of children for the task of interpreting medical details for their parents, claiming it to be unethical, unprofessional, uncivilized and totally unacceptable. This view was criticized by Cohen (1999) saying it is based on moral grounds rather than on systematic empirical analysis, and not considering whether children are always unsuitable for the task; whether the patients who rely on their children are in favour or are reluctant to this practice in the face of no apparent alternative; or whether physicians support or oppose to children as interpreters in general. Cohen reported that the position of Rack (1982) did not hold in practice for GPs in London. The immediate need to proceed with the consultation tended to override physicians' reluctance to place children as interpreters. However, most GPs made it clear that it was unsatisfactory to involve children in "sensitive" consultations related to reproductive health or personal emotional difficulties.

Many health care facilities employ bilingual nurses rather than trained medical interpreters, mainly for economic reasons. Nurses are familiar with physicians' medical assumptions and can elicit the type of information needed for clinical DM. Patients may not view nurses'

presence as invasive in the intimate context of a medical encounter (Elderkin-Thompson 2001). Woloshin (1997) reported that bilingual staff members who received over 70 hours of professional interpreter training made significantly fewer errors than untrained bilingual staff.

A number of studies have examined the impact of interpreting practices on the physician-patient relationship, and confirmed the association between language barriers existing for Spanish-speaking patients and patient dissatisfaction with care, communication, and testing (Blackhall 1995, Carrasquillo 1999, Morales 1999). Baker (1998) found that Spanish-speaking patients who used interpreters perceived their physician as less friendly, less respectful, and less concerned for them as a person than did those who were able to communicate adequately with their physician without an interpreter. However, patients who did not have an interpreter when they thought one was necessary were even less satisfied than those who used one. Most interpreters used in this study were ad hoc interpreters who had not received formal training in interpretation techniques, and only few were hospital trained interpreters. These results cannot therefore be generalized to interpreters who have formal training; nevertheless, these findings have important implications because most institutions rely extensively on untrained interpreters.

Only a few studies have examined which method of interpretation patients themselves find most satisfactory. Lee (2002) reported that Spanish-speaking patients using AT&T telephone interpretation were as satisfied with care as those seen by language-concordant providers, while patients using family or ad hoc interpreters were less satisfied. This suggested that adequate interpretation services enhanced patient satisfaction. The high level of satisfaction with telephone interpreters was established by Hornberger (1996) who considered adapting simultaneous interpretation techniques to the medical setting. In paediatric consultations, mothers and physicians significantly preferred a remote-simultaneous service to a proximate-consecutive interpretation service. Other such resources were also reported on by Pointon (1996) and Hornberger (1997), and indicated that the physical presence of a trained interpreter in the exam room may not be necessary to provide satisfactory interpretation services. Moreover, Jones (1998) suggested that patient confidence in the confidentiality of the consultation may be higher when the interpreter is not present. Kaufert (1997) considered ethical dilemmas arising in interpreting in cases of cultural conflicts and power relationships between patients, healthcare providers, and family members. Conflicts around issues such as truth-telling, obtaining informed consent, and revealing dangerous diagnosis may lead to dilemmas in which the provider must either accede to the interpreter's view of cultural issues, or accept the family's request, or withdraw.

2.5.3 Use of medical terminology

The overuse of medical jargon by heath care providers often confuses health care consumers, leading them to misinterpret practitioners' messages (Barlund 1976). Patient dissatisfaction with communication has been linked to physician's use of technical language or jargon (Daly 1975, Samora 1961, Korsch 1972, Loustaunan 1997). Even when patients do have some familiarity with biomedical terminology, miscommunication may occur, since physicians and patients may use the terminology differently and assign different meaning to the same terms. For example, Gordon (1996) noted low literacy levels in Canadian patients, and the importance of using plain and simple language to communicate with such patients. According to Gorney (1999), one of the most common complaints in patient attitude surveys has to do with use of complex terminology or medical jargon, despite the substantial choice of words available for communicating with patients according to their intellect and educational level.

2.5.4 Verbal communication styles

According to Katriel (1986), stylistic mode of language refers to the tonal colouring given to spoken performances, their feeling tone that invokes the cultural ethos, the moral and aesthetic tone of a culture. Gudykunst (1988) explained that style is a meta-message that contextualizes how individuals should accept and interpret a verbal message, and focused on four stylistic modes of verbal communication: direct versus indirect, elaborate versus succinct, personal versus contextual, and instrumental versus affective. Each of these styles has an impact upon communication in the medical encounter.

2.5.4.1 Direct versus indirect style

The direct verbal style refers to verbal messages embodying speakers' true intentions in the discourse. The indirect verbal style refers to verbal messages that camouflage speakers' true intentions in the discourse situation. The cultural variability dimension of *individualism vs. collectivism* explains the use of direct and indirect styles of verbal communication. Hence, individualism propels North Americans to speak their minds freely through direct verbal expressions. Collectivism constrains members of cultures such as Japan, China, and Korea from speaking boldly, as their cultures emphasizes the importance of group harmony and conformity (Okabe 1983, Gudykunst 1988). Katriel (1986) studied direct and indirect style in Israeli Sabra culture, arguing that *dugri* speech ("straight talk") is the product of the pioneer ideology and the rejection to the Diaspora way of life. *Dugri* speech in Hebrew involves a conscious suspension of face in order to allow free expression of the speaker's thoughts, opinions, or preferences even though they might pose a threat to the addressee.

Katriel also contrasted Sabra *dugri* "straight talk" to Arabic "sweet talk". Arab communication patterns are characterized by the cultural ethos of *musayra,* meaning roughly to go along, to humour, and to accommodate oneself to the position or situation of the other. The high value placed on *musayra* reflects a concern for harmonious social relations and for social regulation of interpersonal conduct. As opposed to Israeli Sabra "straight talk", *musayra* often involves the use of respectful address terms and indirectness. Gudykunst (1988) suggests that Hebrew-speaking Israeli culture is characterized by a low-context, direct verbal style, while the verbal communication patterns of Arab-speaking communities are reflective of some fundamental norms and values in collectivistic, high-context cultures, using indirect verbal style.

2.5.4.2 Elaborate versus succinct style

The elaborate-succinct dimension deals with the quantity of talk as valued in different cultures, and encompass three variations. The elaborate style refers to the use of rich, expressive language in everyday conversation. The exacting style refers to language interaction that contains neither more nor less information than required. The succinct style includes the use of understatement, pauses, and silence in everyday conversation (Gudykunst 1988). The linguistic patterns of people in Arab cultures reflect the use of elaborate style, with fantastic metaphors and long arrays of adjectives used to modify the same word (Shouby 1970, Wolfson 1981, Almaney 1982). Westerners attempting to comprehend Arabic feel the thoughts expressed are generally vague and hard to pin down (Almaney 1982). An elaborate style characterizes many Middle Eastern communication patterns; an exacting style is characteristic of people in many Northern European cultures and the U.S. culture; and a succinct communication style is characteristic of people in Asian and some North American Indian cultures (Gudykunst 1988).

2.5.4.3 Personal versus contextual style

Verbal personal style is individual-centred, referring to the use of certain linguistic devices that enhance the sense of "I" identity. Verbal contextual style is role-centred, and refers to the use of certain linguistic signals that emphasize the sense of "role" identity (Gudykunst 1988). The personal speaking style refers to the use of language to reflect egalitarian social order and symmetrical relations. The contextual speaking style refers to the use of language to reflect hierarchical social order and asymmetrical role positions. The US, Australia and Northern Europe are low-context, individualistic cultures, and their members tend to prefer a personal style of verbal interaction. Cultures of the Far East and Southeast Asia as well as and many

African cultures are high-context, collectivistic cultures, and their members tend to prefer a contextual style of verbal interaction.

2.5.4.4 Instrumental versus affective style

The instrumental verbal style is sender- and goal-oriented, and is concerned with self-face maintenance. The affective verbal style is receiver- and process-oriented, and is concerned with mutual-face maintenance (Gudykunst 1988). Almaney (1988) noted the emotional effect of Arabic on its speakers, leading them to become passionately and unintentionally carried away. This emotionalism sometimes reduces a speaker's ability to think clearly and rationally. Even when speaking a foreign language, Arabs show signs of emotion, a potential source of considerable misunderstanding. Arabs use an affective style of verbal communication, heavily emphasizing expressive non-verbal behaviour, while North Americans are concerned with the digital level of communication. Members of individualistic, low-context cultures tend to engage in instrumental verbal communication, while members of collectivistic, high-context cultures tend to engage affective verbal communication. People in the US, Switzerland, Denmark, and the Netherlands tend to engage in an instrumental style, as these cultures are individualistic and low-context cultures. In most Arab, Latin American, and Asian cultures, speakers engage in an affective interaction style, as they are collectivistic, high-context cultures (Gudykunst 1988).

2.6 Time

This section discusses the concept of time, focusing specifically on time in health care, time and patient satisfaction, time and gender, and time and cultural diversity.

2.6.1 The concept of time

Anthropologists believe that the way in which members of a culture consider and manage time is a clue to how they view the meaning of life and the nature of human existence (Trompenaars 1998). Differences in time orientation have been considered by many investigators (Kluckholn 1960, Pluchman 1978, Samovar 1988, Cushner 1996, Trompenaars 1998, Spector 2000). Kluckholn (1960) identified three types of culture: past-oriented- which is mainly concerned with maintaining and restoring traditions in the present; present-oriented- which is relatively timeless, traditionless and ignores the future; and future-oriented- envisioning a more desirable future and setting out to realize it. The past, as reflected in custom and tradition is more important to Eastern cultures than to Western cultures (Samovar 1981). The differences in time orientation may become important in health care measures such as long-term planning and explanations of medication schedules (Spector 2000).

Hall (1976, 1984) proposed an alternative concept of cultural variability in dealing with time by differentiating between *monochronic* (M-time) and *polychronic* (P-time). M-time is linear clock time, a line stretching from past to future that is divided into compartments or segments known as days, months or years. It is a form of external social organization imposed on people, which is particularly strong in organizations and bureaucracies of the industrial society. P-time is much more human time, where personal relationships take precedence over the rigid schedules. Polychronic people are oriented towards people, the family, and human relationships, involved in multiple tasks, responsibilities, and social ties to other people. In many Western cultures members are dominated by concern with M- time. Persons in P- time are often from Mediterranean or South American cultures. Helman (2001) noted that M-time is a widespread feature of almost all medical institutions throughout the Western world. In these health care settings, the rigid schedules of visiting hours or appointments may be seen by some patients as inhuman and impersonal.

2.6.2 Time in health care

Time has a major impact on human interaction and on the medical interview, as both the health practitioner and the patient will make initial judgments of each other based partially on their respective treatments of the time dimension. Spending more time communicating with others tells them you believe they are important. Conversely, the more time you keep people waiting to interact with you, or interrupt them while they tell about their complaints, the more you imply they are insignificant to you, which may result in loss of trust or respect (Kreps 1992). The right time and correct amount of time spent in rendering professional service are relative, depending on cultural perspective. The traditional authoritarian approach allows the doctor to control the use of time and structure his/her day. It is a clinically-oriented, fairly quick style of consulting, as opposed to the patient-centred approach, which is a less structured, more time-consuming and emotion-seeking style (Tate 1983, Beisecker 1988, Shapiro 1999).

A number of studies have considered such patient complaints as the impression that the doctor is always pressed for time; the belief that a patient cannot interfere with the health professional's standard time frame; and the impression that the patient is often talked about rather than talked to. Practitioners argue that they are short of time and that emergencies often interfere with ideal time constraints, and clients often feel that the practitioners do not take enough time to discuss problems in detail and to listen to concerns (Pluchman 1978, Barlund 1993, Pauwels 1995, Dugdale 1999). Shapiro (1999) investigated family-oriented physician communication, which was correlated with more psychosocial questions, more medical questions, increased active listening behaviours, and greater tendency to elicit the patient's

agenda. Physician adoption of a family orientation was more likely to occur during non-interpreted and longer interviews, two variables that had a strong interrelationship. Although the sample size was small, and restricted to residents rather than to experienced physicians, these findings point to possible approaches for maximizing family orientation, especially in allocating more time for the interview, and in sensitivity to language barriers and cross-cultural issues.

The length of the medical visit was found to vary greatly between countries. In the UK average visit lengths for GPs were found to range between 5 and 8 minutes, whereas in the U.S. and Sweden they were ten to twenty minutes or more (Andersson 1989, Groenewegen 1991, Wilson 1991, Davidoff 1997, Camasso 1994, Dugdale 1999). One factor in visit length is the size of the medical practice. Larger list sizes were associated with shorter consultations and poorer quality of care (Wilkin 1984, Wilson 1985, Roland 1986, Morrell 1987, Wiggers 1997, Stange 1998). Freeman (2002) discussed five important factors that have enhanced consultation content and hence its potential length: participatory consultation style; extended professional agenda; access problems; loss of interpersonal continuity; and health service reforms. Special attention is now allocated to patients' agenda, beliefs, understanding, and agreement to methods proposed by physicians, which usually lengthens consultations. Beckman (1994) described the traditional doctor-patient model of interactions in the US as characterized by a high degree of control by physicians and a more passive role for patients, leaving little room for patients to articulate their concerns. As a result, physicians often remain unaware of patients' beliefs, difficulties, or concerns about diagnostic conclusions and treatment plans, leading to problems with adherence, wasted time, and mutual frustration. Physicians who increased their average visit length from 6.7 minutes to 7.4 minutes asked more questions related to health history and psychological concerns, and made more statements about health education and prevention (Roland 1986).

Howie (1989) examined the association between different consulting styles in general practice and patient care. Short as against long consultations resulted in less attention being given to psychological issues that the physician recognized as relevant. In a national survey of the views of Scotland's GPs on holism in primary care, 87.3% of physicians believed that a holistic approach was essential to providing good health care; however, only 6.8% thought the current organization of primary care services made this possible, due to time constraints and practitioner's own stress level (Mercer 2002a).

The SFAT-AM (Short Family Therapy in Ambulatory Medicine) was developed to cope with the pressure of a heavy workload in an Israeli public clinic, where an appointment lasts on average only 10-15 minutes. A didactic checklist model was developed, which assists the

doctor in planning the meeting, analyzing problematic meetings, and improving the relationship with patients and their families (Eshet 1993). McKinstry (2002) reported on a small randomized control trial of telephone versus face-to-face consultation for requests for same-day appointments. The average time spent phoning and in discussion with patients was 5.2 minutes; the average face-to-face appointments was 8.2 minutes; the average time taken for combined telephone triage followed by face-to-face was 10.9 minutes. Patients dealt with by telephone alone reconsulted 1.5 times more than those dealt with face-to-face, probably wiping out any small gains made.

A number of studies have examined the association between patient socioeconomic status, education level and visit duration. Patient higher socio-economic status and education level was shown to be positively associated with longer consultation time (Bain 1979, Wiggers 1997). Older age was negatively associated with visit length (Keeler 1982).

2.6.3 Time and patient satisfaction

In a meta-analysis of correlates of provider behaviour in medical encounters, the amount of communication was defined in terms of length of interview in minutes, or total number of provider-patient utterances. A greater amount of communication was found to predict greater satisfaction (Hall 1988). Several researchers have considered the relation between time and patient satisfaction. Longer consultation time was found to be positively associated with patient satisfaction (Beckman 1984, Hull 1984, Like 1987, Beisecker 1990, Kaplan 1996, Warde 2001). Patients, who stated they wished they had spent more time with the physician, were less satisfied. Longer interaction may be necessary for an attitude supporting patient DM to manifest itself, and for arriving at mutually acceptable treatment plans.

Morrell (1986) found patients were more likely to feel they had spent inadequate time with their physician in visits scheduled to last 5 minutes, compared with visits scheduled to last 10 and 15 minutes, respectively. Using the same study group, Roland (1986) reported that a general trend for more statements of all types was recorded in surgeries booked at longer intervals. Patients who were booked at longer intervals were more likely to state they had felt "very free" to discuss their problem with the doctor, and were more satisfied with the consultation. Similar results with respect to patient satisfaction were recorded by Camasso (1994), Gross (1998), Lin (2001) and Landen (2003). Visits, in which the physician took the time to chat with the patient, demonstrated a higher level of satisfaction than visits with little or no chatting. An association was found between longer patient-estimated duration of the time spent with the physician, and higher overall patient satisfaction.

Mechanic (2001a, 2001b) studied American doctors' complaints about having insufficient time for patients in spite of an average consultation time of 18.3 to 21.5 minutes. Some explanations lie in the accessibility of health information in the media and the Internet, and the escalation of patients' expectations of doctors. Thus, patients have more questions and conceptions about their care, requiring doctors to spend more time answering questions, comparing treatments, and dealing with misinformation. Keating (2004) identified several factors that increase the likelihood of a trusting physician-patient relationship, all involving time: listening; giving as much information as the patient desires; and involving the patient in DM. Levine (2004) argued that increasing patients' trust requires time, while most practicing physicians perceive that their ability to spend quality time with patients (e.g., not filling out forms, documentations, figuring out health insurance policies) has severely dropped in the past decade. Patient satisfaction and trust are determined not only by actual time spent, but also by how that time matches up with patient's expectations and previous experiences. Therefore, physicians should shift their focus to quality of available time, and an understanding of how best to spend that time (Druss 2003).

Jenkins (2002) claimed that consultations do not have to be longer for patients to have good outcomes. This conclusion arose several critical responses. Roland (2002) observed that some short consultations may be highly effective, but earlier studies, such as Freeman's (2002), summarized a range of improved patient outcomes when doctors have more time. Patients may sometimes get what they want in short visits, but they may not realize that it is not good medical care. Heaney (2002) commented on Jenkins findings, saying that in longer consultations, long-term comorbidity and psychosocial problems as well as the presenting complaint are more likely to be recognized and addressed. Lee (2002) claimed that Jenkins did not address the nature of the consultation. When patients' problems are multifactorial, time is of the essence.

2.6.4 Time and gender

Several studies have considered the issue whether time is spent differently for men and women patients during the medical encounter (Gray 1982, Wilson 1985, Callahan 1991, Roter 1991, Bensing 1993, Bernzweig 1997, Derose 2001, Tabenkin 2004). Visits by women had a higher percent of time spent on physical examination; structuring the intervention; patient questions; screening; and emotional counselling. Visits by men involved a higher percent of time spent on procedures and health behaviour counselling. Male physicians appeared more likely to treat patients differently based on gender than did female physicians (Tabenkin 2004). In two meta-analyses of the effect of physician gender on communication during medical visits, Roter (2002, 2004) found that visits with female physicians were, on average,

10% longer than those with male physicians, and involved more communication that can be considered patient-centred. Same-gender dyads of physician-patient tended to have longer visits than opposite-gender dyads. The longest visits were found between female physicians and female patients and the shortest between male physicians and female patients (Roter 1991).

2.6.5 Time and cultural diversity

A number of researchers have considered the association between cultural conceptions of time and the medical encounter. Tocher (1999) undertook a study in Seattle to determine whether the time physicians spend with non-English-speaking (NES) patients is longer than the time they interact with English speakers. NES group included individuals speaking 22 different languages, the four most common being Spanish, Vietnamese, Russian, and Hindi. There were no differences found in the time the physicians spent providing care to NES patients and English-speaking patients. However, a significant number of these physicians perceived that they were spending more time with NES patients, claiming they are more challenging to care for and require more time during clinic visits due to language and cultural barriers.

Helman (1987) associated coronary heart disease (CHD) with the cultural construction of time, based on Friedman's (1959) "type A behaviour pattern" (TABP) and "type B behaviour pattern" (TBBP). Type A individuals were described as ambitious, competitive, alert and time-obsessed. In contrast, type B behaviour pattern was defined by relative absence of drive, ambition, competitiveness, sense of urgency, and over-involvement in deadlines. For over 20 years, the image of the coronary-prone "type A" individual has been a familiar feature of cardiology literature and can be regarded as a "culture-bound syndrome", particularly of the middle-aged, middle class business men, and one which condenses key concerns and behavioural norms of the Western industrial society.

Cushner (1996) explained that units of time reference differ markedly between Arab and American cultures. To an American the major unit of time is 5 minutes, and 15 minutes are a significant period of time. To an Arab, the unit of time that corresponds to the American 5-minute block is 15 minutes. Thus when an Arab patient is 30 minutes late for an appointment, according to Arab standards, it is not a significant amount of time.

2.7 Gender

This section first discusses the concept of gender cultures in general. It then surveys gender and health care, focusing in particular on gender as it affects physician communication styles, patient preferences, patient satisfaction and cultural diversity.

2.7.1 Gender Cultures

The term "sex" is used to refer to biological sexual differences between people. Before the mid-1970s, communication studies considering sex differences categorized people on the basis of biological differences and observed differences in communicative behaviour. In 1974, Bem created a new conceptualization of sex roles, the Bem Sex Role Inventory, which radically altered the way women's and men's roles were categorized, suggesting that masculinity and femininity are separate dimensions. Hence, people should be categorized according to the extent to which they internalize society's standards for masculine and feminine behaviours. As sex roles became a psychosocial rather than a physical variable, studies began to talk about gender rather than sex. While sex still refers to biological differences between people, gender refers to internalized predispositions to masculine and feminine roles (Pearson 1988).

Culture contributes a set of guidelines acquired from infancy onwards which tell individuals how to perceive, think, feel, and act as either male or female members of their society (Helman 2001). All societies assign a division of labour to each gender to one degree or another (Kreps 1994). Attributes such as strength, assertiveness, competitiveness, and ambitiousness are typically considered masculine traits; whereas attributes such as affection, compassion, nurturance, and emotionality are typically considered feminine (Bem 1974, Hofstede 1982, Loustaunan 1997).

2.7.2 Gender and Health Care

Helman (2001) called the beliefs, expectations, and behaviours inherent in a particular gender culture the "disease of social gender." The gender roles prescribed by a particular gender culture may, like other cultural beliefs and behaviours, be either protective of health or pathogenic. For example, compared with women, men are encouraged to drink more alcohol, smoke more cigarettes, be more competitive, and take more risks in their daily lives. In face of suffering and pain, men are expected to have an unemotional language of distress and be uncomplaining, with a high threshold for consultation with a doctor. In many cases, this behaviour may lead men to ignore early symptoms or cause doctors to underestimate the seriousness of a disease. By contrast, women are socialized to have a low threshold for

consultations with doctors and display a more emotional language of distress. This may lead to a misdiagnosis of hysteria or hypochondria by male physicians and unnecessary use of drug therapy. However, frequent consultations may also aid in early recognition of certain diseases.

Men and women vary in their perceptions of symptoms, assessment of symptom severity, and readiness and ability to take curative actions. Diagnostic criteria reflect attitudes, beliefs, and values instilled in health care professionals in the society they grow up in, leading to different labelling, diagnoses, and treatment of men and women (Verbrugge 1985, Loustaunan 1997). Gender stereotypical assumptions about patients influence physicians' interpretation of medical symptoms and their management, and can be found in the interactions between physicians and patients, in textbooks and laboratories (Scully 1979, Colameco 1983). Women's complaints were judged more likely to be influenced by emotional factors, and identified as psychosomatic more frequently than men's (Bernstein 1981). The logic of the representational mode of medicine implies that physicians use objective findings to discriminate "real" from "unreal" disease. A remarkable majority of women compared to men suffer from "undefined" medically unexplained disorders. Their subjective symptoms are denied medical validity, and overruled by the lack of objective findings (King 1982, Malterud 1999).

2.7.3 Gender and Physician Communication Styles

A possible explanation for gender differences in health care is that men and women tend to have different styles of communication, which parallel gender differences in other contexts (Street 2002). Numerous researchers have considered the differences in physicians' and patients' communicative styles (Wallen 1979, Buller 1987, Hall 1987, 2002a, Tannen 1990, Street 1991, Roter 1991b, 2004, Anderson 1993, Bensing1993, Ong 1995, Koss 1997, Van den Brink-Muinen 1994, 1998, Ong 1995, Bertakis 1995, Koss 1997, Bernzwieg 1997, Tabenkin 2004).

Buller (1987) identified prevalent physician communication styles as "affiliative", more common with female physicians, and "controlling", as more common among male physicians. Patient satisfaction was positively associated with physician affiliative behaviours and negatively associated with physician controlling behaviours (Buller 1987, Anderson 1993, Aruguete 2000).

The expectation that female physicians are less likely to use aggressive communication strategies than male physicians, and are more interested in emotional aspects of health, may

explain why male and female patients tend to talk more, ask more questions, reveal more psychosocial information, and are more involved in DM when interacting with female physicians (Roter 1991a, Hall 1994a, Street 2002). The fact that female physicians exhibit more patient-centred behaviours and are more concerned with psychosocial issues than male physicians is consistent with evidence indicating that they are more interpersonally oriented, concerned with emotional and social aspects of health, and interested in patient's partnership (Giles 1994, Elderkin-Thompson 1999, Krupat 2000, Street 2002). Female physicians also tend to ask more open-ended questions, spend more time building rapport, and provide more biomedical and psychosocial information (Maheux 1990, Roter 1991a, Roter 1991b, Hall 1994a, Bertakis 1995). Male physicians may take a more individualistic and instrumental approach to health management and therefore spend more time focusing on biomedical issues, expressing opinions, and making recommendations (Elderkin-Thompson 1999, Street 2002).

Patients of female physicians had more participatory visits compared to patients of male physicians (Cooper-Patrick 1999), and visits of male patients were less participatory than those of female patients (Kaplan 1996). Roter's meta-analytic reviews (2002, 2004) found that female physicians conducted longer visits than male physicians, engaged in significantly more active partnership behaviours, positive talk, psychosocial counselling, psychosocial question-asking, emotionally focused talk, and communication that can be considered patient-centred. Same-gender dyads tended to have longer visits than opposite-gender dyads (Roter 1991a).

Gender-based perceptions may also affect how patients talk to health care professionals (Street 2002). Female primary care patients and practitioners frequently deal with issues deriving from gender roles in the family and at work, which lead to emotional disturbances as well as difficulties in achieving role expectations when physical illness occur (Borge 1995).

2.7.4 Gender and Patient Preferences

Hopkins' (1967) study was among the first to report that when given the choice, women patients preferred a female GP in an urban group practice. Later studies also found that female patients chose a female GP more often than male patients if and when they had the opportunity, and this tendency was stronger if there was more opportunity (Kelly 1980, Fennema 1990, Bensing 1993, Watson 1999). Table 1 summarizes results concerning patient preference of physician gender.

Table 1: *Patient Choice of Physician Gender*

Studies	Female Physicians	Male Physicians	Gender preference	No Gender preference
GP patients				
Female patients in urban group practice (Hopkins 1967)	68%	52%		
Female patients (Challacombe 1983)	77% +	60% -		
Female patient % of total workload in Dutch study (Bensing 1993)	71.1%	55.3%		
Family Physicians				
Male Patients (Kelly 1980)	33.6	46.2		
Female Patients (Kelly 1980)	66.4%	53.8%		
Female patient preference (Fennema 1990)	43%	9%		47%
Male patient preference (Fennema 1990)	12%	31%		57%
Overall health care				
Canadian European-descent (CED) Immigrant women (Ahmad 2002)	46.8%			53.2%
CSA - Canadian South-Asian (CSA) Immigrant women (Ahmad 2002)	60.5%			39.5%
Primary Care Physician (Schmittdiel 2000)				
Patient preference	36.4%	12.5%		
Female preference			50.5%	
Male preference			41.9%	
Anal or genital examinations				
Female preference (Fennema 1990)	57%	9%		
Male preference (Fennema 1990)	64%			
Canadian European-descent (CED) Immigrant women (Ahmad 2002)	72.9%			27.1%
CSA - Canadian South-Asian (CSA) Immigrant women (Ahmad 2002)	83.7%			16.3%
Obstetrician				
Dutch Female patients (Kerssens 1997)	42.2%	5%		52.8%
Emotional/Behavioural Problems				
Depression and Family Problems (male/female) (Fennema 1990)	41%	9%		
Psychologist (Kerssens 1997)	18.4%	3.1%		78.5%
CED & CSA Immigrant women (Ahmad 2002)	Ca.50%			Ca.50%
Nursing				
Dutch Female patients (Kerssens 1997)	35.45%	0.2%		64.6%

2.7.5 Gender and Patient Satisfaction

The association between patient satisfaction and gender has been evaluated by a number of researchers (Linn 1984, Hall 1988, Bertakis 1995, 1994b, Roter 1998, Schmittdiel 2000, Derose 2001,). Hall (1988) found that patient satisfaction was dramatically predicted by the amount of information imparted by the provider, and that providers gave more information to female than to male patients. Female patients were more satisfied with the medical care than men, and physician behaviours reflecting personal concern and availability were significant predictors of overall satisfaction. Male patients were more satisfied when they felt their physician spent time presenting information and engaging in an active dialogue (Lieberman 1989). Derose (2001) reported that physician gender was not associated with male patients' satisfaction. Female patients visiting female physicians reported greater satisfaction with time spent, concern shown by physician, overall satisfaction, and trust.

2.7.6 Gender and Cultural Diversity

In almost every culture, most primary health care takes place within the family, usually by women and often by mothers and grandmothers. Within the popular sector, women have often organized themselves into healing cults, circles, and churches. Within the folk sector, women have always played a central role, from the village "wise woman" to the many female folk healers in the non-industrialized world. In the professional sector of modern medicine, however, while the majority of health care professionals (nurses and midwives) are still female, the higher prestige jobs are usually held by male physicians (Helman 2001).

Cultural differences in gender attitudes and patient ratings of physician behaviours have been considered in many studies (Hooper 1982, Pasick 1996, True 1996, Britt 1996, Kerssens 1997 Roter 1998, Van den Brink-Muinen 1998, Cooper-Patrick 1999, Derose 2001, Ahmad 2002). Cultural beliefs, norms, and values affect the manner in which health, illness prevention, and sources of treatment are perceived. Asian health-seeking behaviour patterns, including preferences for physician gender, may be modelled within the extended family, unlike in North America and in West European countries where priorities may lie with individualistic perspectives (Pasick 1996, True 1996). Van den Brink-Muinen (2002) investigated differences between gender-dyads across and between six European countries, taking into account patient and GP gender, and consultation styles. Differences were found mainly between female-congruent dyads and other dyad groups.

2.8 Patient Satisfaction

Pascoe (1983) defined patient satisfaction as a health care recipient's reaction to salient aspects of a service experience. Satisfaction is assumed to consist of a cognitive evaluation and an emotional reaction to the service. Patient satisfaction with physicians is an important component of the quality of health services, since it has been linked to health outcomes through its impact on patient recall and adherence to therapeutic recommendations. Patient satisfaction may reflect the types of interventions patients felt they received during a medical visit and the congruence between the interventions they desired and those they received (Brody 1989). It may also be a useful measure in assessing consultations and patterns of communication, such as success of information-giving; mutual DM; and reassurance; and has been related to whether patients return to or change the health care provider (Fitzpatrick 1991a). More satisfied respondents were less likely to report having seen multiple physicians or having changed providers. Patients who reported having a usual provider during the preceding year tended to be more satisfied with access; convenience; availability of hospitals; interpersonal and technical aspects of medical care quality; and satisfaction in general (Ware 1975, Kasteller 1976).

Findings regarding patient satisfaction are useful for program planning, evaluation, and identification of potential areas of improvement, and can provide a measure of service failure and service failure recovery (Ford 1997). Most research on patient satisfaction indicates that the majority of patients report being satisfied with their overall care, although more specific questioning can yield higher levels of criticism (Locker 1978).

The following discussion focuses on determinants and measures of patient satisfaction as well as on the role of cultural diversity in patient satisfaction.

2.8.1 Determinants and measures of patient satisfaction

In medical communication, an important distinction is made between instrumental or task-focused behaviour (cure-oriented) and affective or socio-emotional behaviour (care-oriented). Instrumental utterances include behaviours such as giving information, asking questions, counselling, giving directions, identifying future treatment or tests, discussing side effects and test results, and explaining reasons for treatment or nontreatment. Affective utterances consist of behaviours that are very encouraging, relaxed, extremely friendly, open and honest, show concern and empathy, give reassurance, show approval, introduce self to patient, touch, and engage in small talk. Research has paid much attention to instrumental-focused exchange, especially information-giving and information-seeking by doctors and patient (Ong 1995).

Patient evaluations of health care have generally been assessed through patient satisfaction surveys (Pascoe 1983, Fitzpatrick 1984, 1991a, 1991b, Linder-Pelz 1985, Bowling 1999). Questionnaires of patient satisfaction take one of two forms: episode specific or more general in terms of the focus of the questions. Questionnaires with more episode specific content were found to produce more uniformly favourable responses from patients, compared with somewhat more negative views elicited by generally worded questions. The argument for episode specific questionnaire items is that they reflect more accurately individuals' actual experiences, and result in more variations in answers (Pascoe 1983, Fitzpatrick 1991a). Numerous studies have attempted to assess patient satisfaction (Ware 1975a, 1975b, 1983, 1988, Ben-Sira 1976, Donabedian 1980, Kasteller 1976, Marquis 1983, Davies 1991, Baker 1991, Bowling 1999). Ware (1983) made the distinction between objective satisfaction reports about providers and care such as waiting times, and satisfaction ratings attempting to capture a personal evaluation of care. Satisfaction ratings reflect three variables: the patient's personal preferences; the patient's expectations; and the realities of the care received. Linder-Pelz (1985) emphasized the multidimensionality of patient satisfaction and argued that patients evaluate several distinct aspects of a visit, rather than simply reaching one overall assessment.

In general practice, satisfaction was most appropriately measured immediately after specific consultations, rather than attempting to measure general satisfaction with medical care (Hulka 1971). Cleary (1988) summarized the factors thought to be related to patient satisfaction: patient socio-demographic characteristics; physical and psychological status; attitudes and expectations concerning medical care; the structure, process, and outcome of care. Much of the variability in results is likely to be due to differences in the questions asked, the timing of administration, and the setting in which care was received (Like 1987, Lebow 1974, Linn 1982, Cleary 1988, Fitzpatrick 1991b).

Patient satisfaction measures are sensitive to and confounded by patients' perceived health, view of life, and social circumstances (Linn 1982). A consistent determinant characteristic affecting satisfaction is patient age, suggesting that older patients tend to be more satisfied with health care than younger people (Houts 1986, Blanchard 1990, Zahr 1991, Williams 1991a, Owens 1996, Greenhow 1998). Lower levels of education were found to be associated with greater satisfaction, and higher educational attainment was associated with dissatisfaction (Hall 1990b, Anderson 1993, Schutz 1994). A number of social-psychological artefacts were also found to affect expressions of patient satisfaction (LeVois 1981): (1) "social desirability response bias"- arguing that patients may report greater satisfaction than actually felt because they believe positive comments are more acceptable to survey

administrators; (2) "ingratiating response bias"- that occurs when patients use the survey to ingratiate themselves with researchers or medical staff (Raphael 1967, Ley 1972); (3) "self interest bias"- when clients are likely to perceive that expressing satisfaction will contribute to the continuation of the service; (4) "cognitive consistency theory"- suggesting that patients are likely to report satisfaction as a way of justifying the time and effort they have invested in their treatment. "Gratitude" was recognized as confusing results, and has often been associated with elderly patients, who felt unable to express desires, fears, or criticism to medical staff (Tagliacozzo 1965, Owens 1996). Ley (1972) added indifference as a factor, whereby patients may feel problems will not be remedied, so there is no point in commenting on them.

Ware (1976, 1978) raised concern about the effect of response biases on the reliability of satisfaction measures and on the levels of satisfaction obtained. Agreement with positively worded items was found to result in higher levels of satisfaction; whereas agreement with negatively worded items resulted in lower measured satisfaction, thus overestimating or underestimating levels of measured satisfaction. Different measurement methods were found to provide very different results (Ross 1995, Meakin 2002, Poulton 1996). A positive response in a satisfaction survey should not be interpreted as indicating good care, but simply that nothing "extremely bad" occurred (Williams 1994). A model of satisfaction gaining favour among researchers discredits the value of positive results in satisfaction studies. The "discrepancy" model argues that satisfaction is relative, defined in large by the perceived discrepancy between patients' expectations and actual experience (Sitzia 1997).

Increased interest in patients' views as a necessary component of evaluating care quality has led to the development of many measurement instruments. Prior research pointed out that the measurement of satisfaction does not necessarily reflect patients' perceptions of quality of care (Haddad 2000). Satisfaction includes a highly affective dimension, and seems to be more dependent on patient expectations than is perception of quality (Kravitz 1997, Cleary 1998). Peck (2001) argued that no standardized assessment instrument exists for studying patients' expectations, as these expectations range from a desire for information or psychological support to expectations for specific tests or treatments. The particular method employed in a study measuring patient satisfaction should be determined by the purpose of the research and the specific setting. Varying cultural attitudes to health care mean, that scales need re-evaluation before applied in different settings (Kinnersley 1996).

2.8.2 Patient satisfaction and cultural diversity

Fitzpatrick (1984) identified "the need for the familiar" model of patient satisfaction, which argues that patients' socially created expectations are the primary determinant of degree of satisfaction. A number of studies have considered the relationship between culturally determined expectations and satisfaction (Madhoc 1992, Biderman 1994, Porter 1994, Hahn 1995, Baider 1995, 1997, Sitzia 1997, Braboy Jackson 1998, Jones 1988, La Saha 1999, Braboy, Howard 2001, Laveist (2002). Patients from non-Western cultures are not familiar with the Western approach, and are thus unlikely to be happy with it. When patients come from cultural traditions or social classes that differ from those of the physicians, they may believe they are not heard, understood, or responded. In the UK, surveys identified as key problems language difficulties of Asian patients (Jones 1988). The cultural expectations of women from Asian communities are prominent in studies, and in particular the examination of Muslim women by male doctors was highlighted as a source of distress (Madhoc 1992). Laveist (2002) examined a US national sample of African-American, white, Hispanic, and Asian-American patients to test the hypothesis that doctor-patient race concordance is predictive of patient satisfaction. All respondents reported greater satisfaction with physicians from their own race.

For patient satisfaction with information see Section 2.2.2; with participatory decision-making see Section 2.3.4; with overcoming language barriers and interpreter use see Section 2.5; with physician's interpersonal communication see Section 2.4.3; with time see Section 2.6.3

2.9 Summary

The vast body of research investigating the various factors influencing the physician-patient relationship demonstrates the complex and multidimensional nature of this unique encounter. Although each factor was addressed separately, taken together these aspects were found to have interactional and reciprocal influences that work to strengthen or diminish the success of relations between physicians and patients, and thus the results of the medical encounter.

Physicians, as products of their own cultures, their medical training and their occupational sub-culture, may not be aware of the social, cultural and psychological dimensions of ill health and the context in which it appears. They may not understand that this context determines the meaning of health and illness for each individual patient. This lack of awareness was found to influence crucial medical concerns, among them proper diagnosis, treatment recommendations, communication between patient-physician and family, treatment

decision-making, patients' use of services, patients' willingness or ability to follow recommendations, patient and physician satisfaction and health outcomes.

Referring patients to culture-congruent physicians was recommended by some researchers and wished for by minority patients. Other researchers, however, have argued that ethnicity alone does not guarantee physician cultural awareness and sensitivity.

The way in which information is transmitted to the patient was found to have a major impact on levels of anxiety and stress, patient compliance, medical outcomes and patient satisfaction. Individual physicians were found to differ on the extent to which they provide medical explanations, where the amount of information given was dependent on the mutual and reciprocal expectations, perceptions, attitudes and communication skills of both participants. Patients almost always wanted as much information as possible, yet doctors often were not aware of this. It is also unclear to what extent doctors and patients agree about the amount and type of information that should be disclosed. Mass education, mass media and mass consumerism have put an increasing amount of pressure on professionals to meet rising patient expectations.

Currently, there are no evidence-based guidelines for discussing clinical evidence with patients in the medical decision-making process. Nevertheless, the nature of communication in the health provider-health consumer relationship is changing as a result of the growing trend in health care away from the traditional paternalistic model, in which the physician prescribed and the patient complied, and toward a model in which the patient takes an active role in making decisions. A shift has occurred in examining how patients take prescribed medication, from a model of compliance to the concept of adherence. Today, the relationship between practitioners and patients is considered in terms of concordance, participatory decision-making, shared decision-making or mutual decision-making. Sharing decisions addresses the increasing need to recognize patients' rights and autonomy, and the idea that patients and physicians should work together towards an agreement on treatment choice.

While patients were found to definitely want information in each of a wide variety of medical areas, they seemed hesitant to assume responsibility for making medical decisions and felt that medical decision-making authority should rest more with physicians than with patients. A more participatory style was found to be related to patient satisfaction. Cultural differences in decision-making may lead to conflicts or misunderstandings, particularly when non-Western patients from collectivistic cultures are asked to make independent health care decisions.

Language barriers were found to impair the exchange of information between patient and physician, and to result in incomplete patient education, misunderstood instructions and patient dissatisfaction. Language barriers disarm patients' ability to assess meaning, intent, emotions, and reactions, and create a state of dependency on the interpreter. Nevertheless, the presence of an interpreter may change the dynamics of the interchange, making the patient more inhibited about interrupting or seeking further information. Moreover, many clinics and hospitals cannot afford interpretation services and call upon staff members or friends and relatives of the patient to serve as translators. These people are often ill prepared to deal with the complexities of interpreting.

Traditionally, medical practitioners who adhered to the scientific, paternalistic medical model have sought to avoid the medical milieu of emotion. Yet attitudes and beliefs about the role of emotions are changing in contemporary medicine, and research studies have begun to explore physicians' personal socio-emotional communication styles. Patient satisfaction was found to increase with more information given by physicians, greater technical and interpersonal competence, more partnership building, more social conversation, more positive and less negative talk, and more communication overall. Compared to male physicians and their patients, female physicians and their patients were found to conduct longer medical visits with more talk, and to engage in more positive talk, partnership building, question-asking and information-giving.

Physicians' and patients' cultural concepts of time may be congruent or incongruent, therefore leading to increased understanding or misunderstanding during the medical encounter. Longer consultations have been associated with better recognition and handling of patients' psychosocial problems, greater patient participation, increased patient education and patient satisfaction. Visit length was found to vary greatly, depending upon specialty and country. The optimal visit length for a given patient or a clinical problem cannot be generalized. Nevertheless, a patient-centred approach that advocates attention to a patient's beliefs, needs, understanding and agreement was usually found to lead to lengthened consultations. This was mostly welcomed by patients, but places more pressure on physician's limited time.

Gender socialization affects a person's life chances, behaviour and beliefs in that certain educational, occupational and even health opportunities have often been reserved for one gender or the other. Diagnostic criteria reflect attitudes, beliefs and values instilled in health care professionals, leading to differences between men and women patients in labelling, diagnoses and treatment. The expectation that female physicians are less likely to use aggressive communication strategies than are male physicians and that they are more

interested in emotional aspects of health may explain why male and female patients were found to talk more, ask more questions, reveal more psychosocial information and be more involved in decision-making when interacting with female physicians. Women physicians were found to spend more time with their patients, and female patients had longer visits than male patients.

Various factors are thought to be related to patient satisfaction: patient socio-demographic characteristics, physical and psychological status, attitudes and expectations concerning medical care, and the structure, process and outcome of care. There is no consensus about which of these factors is most important, and results of different studies appear to depend on the type of care rendered, the context in which it was studied and the survey instrument used.

The modern health care system is a cultural melting pot, comprised of individuals from different combinations of national, regional, ethnic, socioeconomic, occupational, generational and health-status cultural orientations. Health care practitioners are advised to learn about the different culturally-based heath expectations, beliefs, values and attitudes that influence patients' interpretations of health, illness and health care in order to bridge intercultural gaps and produce desired results, such as effective management, friendship and conflict resolution.

2.10 Study Hypotheses

The three hypotheses of the current study are as follows: (1) Patients from the three culture groups will exhibit differences in attitudes, needs, expectations, and satisfaction regarding the examined aspects of the medical encounter. (2) Patients from the three culture groups will exhibit differences in attitudes, needs, expectations, and satisfaction with respect to the interaction between patient and physician culture. (3) Patients in culture-congruent groups will report that their needs, expectations and satisfaction were met to a higher degree than will patients in culture-incongruent groups.

Chapter 3 Personal In-Depth Interviews

3.1 Introduction

A total of thirty in-depth interviews were conducted. Ten patients from each of the three cultures were interviewed: Jewish-Israeli (JI), Arab-Israeli (AI) and immigrants from the former Soviet Union (FSU). These personal interviews were conducted as part of a two-stage pilot research. In the first stage, a pre-test was conducted using the Attitude and Satisfaction Questionnaire; the pre-test involved forty-five patients, fifteen from each of the three cultures. During the second stage, thirty in-depth interviews were conducted with thirty patients. The results of these two stages served to produce the revised version of the questionnaire, on which the field study was based. Moreover, the results of the in-depth interviews provided meaningful information on patients' personal experiences and attitudes that complemented the results of the field study; this information was integrated into the discussion (chapter 6).

3.2 Objectives

In-depth individual interviews are generally chosen as the most appropriate method when the purpose of the research is to expose beliefs, perceptions, attitudes and opinions that are otherwise hidden in people's minds. This form of interviewing seeks to understand the meaning individuals associate with events and relationships in their lives (Berglund 2001).

The thirty in-depth interviews were conducted in order to provide insight into the patients' attitudes, needs and expectations from a medical encounter with their physicians. The interviews were designed to strengthen the understanding of how patients evaluate the various aspects of the physician-patient relationship that were of concern in this study: information-seeking and giving, participatory decision-making (PDM), physician's interpersonal communication, verbal communication, time and gender. In addition, questionnaire items from pre-test 1 that had caused patients difficulties were examined as well. The causes of these difficulties were sought, and attempts were made to rephrase the items accordingly.

3.3 Methodology

According to Berglund (2001), in the health arena there are four qualitative data collection methods that are commonly employed: individual, in-depth interviews; focus group discussions; document interpretation, and; participant observation. Ethical considerations regarding respect for patient privacy and anonymity as required by the Helsinki Ethical Committee of the Bnai-Zion Medical Centre for both parts of the study prevented the

researcher from using additional evaluation tools, such as recording the interviews. Thus, the method of in-depth individual interviewing was chosen to explore patients' perceptions and feelings. The term interview is used to describe anything from informal chats to highly structured questions and answers sessions (McQueen 2002). Patton (1990) suggested that there are three types of in-depth interview which result in qualitative data: the informal conversational interview, the general interview guide approach, and the standardised open-ended interview. The general interview guide approach is the most commonly used in the area of health research. The researcher sets out to seek answers to a series of questions, however, the sequence and actual wording are flexible and the interview guide takes the form of a reminder. Moreover, the researcher goes into the interview prepared to deviate from the set of questions or topics (McQueen 2002).

The interviews were based on the Personal Interview Guide (Appendix A), which was developed with the aid of an anthropologist. The questions were phrased in an open-ended way to elicit a response that expresses the interviewee's unique perspective and draws upon his or her individual experience. The open-ended phrasing allows for free response, does not restrict the range of answers (Berglund 2001), and enables respondents to choose their own terms (Silverman 2001). The interviews conformed to the sequence of the Personal Interview Guide; however, when the responses deviated to other aspects or experiences, the researcher did not cut off the respondent's train of thought. Hence, the sequence and actual wording used during the interview were flexible, and the interview guide took the form of a checklist rather than a collection of questions set in a rigid sequence. The resulting free dialogue allowed the interview to flow naturally, enabling the interviewee to focus on whatever was relevant to him or her, and to explore any new information volunteered. This approach resulted in data in the form of flowing narrative.

The interviewees were chosen from the patient population as representatives of the three culture groups. Since perceptions are likely to vary between individuals, and both information and individual experiences were sought, it was decided to interview ten patients from each culture, rather than relying on a smaller number of interviewees.

Thirty patients were interviewed: ten Jewish-Israeli patients, ten Arab-Israeli patients, and ten immigrant patients from the former Soviet Union. Patients ranged in age from twenty-three to eighty years old. Patients were personally approached by the researcher, given a short explanation about the study, and asked to participate. Those who agreed were promised anonymity and confidentiality of their answers. Each interview took place in a designated room.

The presence of an interpreter was found to change the dynamics of an interview, and even manipulate the information exchange (Putsch 1985). To achieve unity in the interview style and to avoid any potential effects of translation or of bilingualism (see chapter 2.5.2 verbal communication), the same interviewer (the researcher) conducted all the interviews with patients from all three cultures. All thirty interviews were conducted in Hebrew. Therefore, the AI patients and the FSU immigrant patients chosen to participate in the study were all bilingual and relatively proficient in Hebrew. Several female AI patients who were approached reported minimal proficiency in Hebrew, making them unable to participate in a long interview.

Berglund (2001) claims that skills of in-depth interviewing become those of good interpersonal communication, since a dialogue is developed between interviewer and interviewee. For people to be able to reveal deep elements of their personal values, an atmosphere of trust is necessary. The interviews therefore had no time limits, as it was believed that adequate time must be allowed to establish the desired atmosphere. All patients interviewed agreed in advance to participate in a long interview, which lasted for at least one hour.

Silverman (2001) argues that tape-recording or original documents usually provide a solid body of original data. Where these cannot be used, the field researcher must attempt to transcribe as much as possible of what is said. Field notes were taken during the interviews, and special efforts were made to write down patients' statements that seemed important. Immediately after each interview, the researcher recorded more elaborate notes on the information, thoughts and reflections offered by each patient. As most of the interviews were long and required considerable efforts for documentation, only two interviews were conducted per session.

According to Berglund (2001), qualitative analysis has traditionally been less reliant on computers compared to the analysis of quantitative data. The original methods for analysing interviews and focus group feedback relied on reading and re-reading the written data and analysing it for themes, often by cutting and pasting pieces of text by hand. The data obtained is unique to the researcher and study population, and is the product of their interaction. Over the last two decades a number of computer programs have become available to assist in codifying qualitative data, which have benefits and limitations. While making manipulation of large pieces of text easy, they force the researcher in a certain way of viewing the data, which may inhibit the intuitive flow of ideas that had occurred between researchers and their subjects.

According to McQueen (2002), the best way to approach the analysis of field notes is to write them up in some structured way, depending on the focus and orientation of the research. Analysis is likely to involve a search for consistencies and variations in interviewee's information. After all thirty interviews were completed, the data was written up manually following the order of the predetermined aspects identified in the Personal Interview Guide. Both individual and group (culture group) consistencies and variations were sought, which focused on the responses to the particular questions, and on narratives that were offered on particular issues (Appendix B).

The essential component of this part of the analysis was to revisit the questions and reorganise the data with respect to each question. The data was displayed in a concept map that revealed patterns and indicated relationships among the various aspects. Smaller categories were arranged into the predetermined conceptual aspects, and patterns were sought in their relationships to each other. An anthropologist read all the field notes and post-interview documentation and validated the thematic analysis of content identified by the researcher.

The resulting conceptual map was written up in narrative form, with all pertinent findings supported by quotations documented in the field notes. The quotations served two purposes: (1) verifying the report and indicating how the findings emerged from the data; and (2) enriching the descriptive findings.

The patients' statements were translated into English, and efforts were made, with the aid of an interpreter, to obtain conceptual equivalence rather than lexical correspondence. Several expressions were difficult to translate due to their underlying profound meaning, which may be lost in the translation. One example is the expression *"ben adam"*, literally translated as "person" or "human being". In the context in which it was used by the patients, however, as in *"I want my physician to first of all be a ben adam"*, the expression denotes the notion of being humane and compassionate, having a devoted and caring attitude, equivalent to the Yiddish word *"mensch"*.

3.4 Results

The results of the in-depth interviews focus on the following aspects: patient's recall of past medical encounters; information-seeking and giving; participatory decision-making; verbal communication; time; physician's interpersonal communication; gender; the "ideal" physician.

3.4.1 Patients' recall of past medical encounters

As an introduction to the interview, patients were asked to recall a medical encounter that had a special meaning for them. All patients spontaneously addressed the same categories in speaking of their experiences with physicians, even though they had not been advised to choose these aspects: physician's communication style, information-seeking and giving, and time devoted by the physician. Eight patients reported positive experiences and were appreciative and satisfied. All thought that encounters should always evoke positive feelings, yet none claimed that this is always the case. Fifteen patients recalled negative encounters and were very emotional when talking about their experiences. Most of them were still angry or irritated and upset when describing the physician's attitude. The physician's communicative style, whether positive or unpleasant, deeply affected patients' memories of the encounter. Patients valued physicians with a friendly and caring communicative style. One AI female patient said: *"He treats me with a personal touch, and I consult him about my personal issues"*.

Patients who recollected negative visits bitterly complained about physicians who left them with the impression that they did not care about them as suffering human beings. A JI male patient reported: *"The physician treated me as a specimen and not as a patient and a human being, and he did not address my suffering"*. AI patients, particularly females and FSU immigrant patients not proficient in Hebrew complained of a lack of personal communication with their JI physicians.

Information-giving by the physician was highly valued by all patients who expressed a desire and need for it. An AI female patient spoke of her physician: *"Who volunteered a lot of information, which made us share a common language, and made me feel that the doctor treated me like a friend"*. Those patients who complained of lack of information all thought it prevented them from better understanding their medical problems and treatment. All patients reported question-asking as valuable, and those who were unable to ask as many questions as they had wanted all reported anger, frustration and hurt.

Most patients shared the opinion that physicians suffer from a lack of time. Even though some patients seemed to understand that physicians are always very busy, they still felt they deserved to spend more time with their physicians. Short visits were believed to have a negative effect on the atmosphere as well as on their knowledge and understanding of their medical problem and treatment. AI female patients as well as FSU immigrant patients who suffered from a language barrier with JI physicians reported that lack of time added another burden to their difficulties in the encounters. They felt the physicians did not take enough

time to overcome the lack of communication due to the language barrier, leading to misunderstandings, frustration and insufficient information.

3.4.2 Information-giving and information-seeking

3.4.2.1 Sources of patients' information

Of the ten JI patients, only two male patients consulted an additional physician other than their treating physician. Of the ten AI patients, only three patients, two males and one female, also consulted with their family physician, with whom they were able to speak Arabic. Finally, of the ten FSU immigrant patients, five females and two males received information from both the treating physician and their Russian-speaking family physician. Four FSU immigrant patients attributed their understanding of the information to their consultations with both the Hebrew-speaking treating physicians and the Russian-speaking family physicians.

These findings may suggest that Hebrew-speaking JI patients and AI patients do not feel the need to consult other physicians because they understand the information provided by their treating physicians. FSU immigrant patients were found to seek further information from language-concordant family physicians, and to have a better understanding of their medical problems and treatment after doing so.

3.4.2.2 Information sufficiency

The majority of JI patients (seven patients) and AI patients (nine patients) reported they received sufficient information from their physicians. One JI female patient said: *"I trust my doctor that he has the knowledge and he is excellent, and I do not need any other sources"*. Nevertheless, five JI patients and three AI patients wanted to receive additional information. Seven FSU immigrant patients felt they had not received enough information from their physicians, claiming they wanted to receive more information. These results point to a feeling of dissatisfaction among FSU immigrant patients regarding sufficiency of information received from physicians.

3.4.2.3 Additional sources of patient information

Of the thirty interviewees, eighteen- six JI, five AI and seven FSU immigrants, sought more information after having consulted with their treating physicians. Five FSU immigrant patients, who consulted both their treating physician and Russian-speaking family physician, still wanted more information about their medical problem. All twelve patients who spoke to family members felt the need to talk to them about their medical problem, but did not expect

their relatives to provide medical information. One patient commented: *"I tell my children what the doctor said, but I trust the doctor, because they are not doctors"*.

The sources of further medical information varied. One source was printed material from medical books, encyclopaedias, and publications on alternative medicine. Other sources were friends, other patients suffering from similar medical problems, and other specialist physicians. All seven patients who searched the Internet were unable to find useful information.

These results may suggest that patients are eager to receive information concerning their medical problem. All patients who sought further information felt that the treating physician did not provide all the information they desired, so they turned to various other sources. However, the information from these sources only partially contributed to the knowledge of their problem.

3.4.2.4 Informing physicians about seeking further information

Ten of the fifteen patients who sought additional information addressed the issue of informing their physician. Five did not want to tell their physician about their search for more information because they did not want to offend their physician or because they thought the physician would consider this a breach of authority. Five told their treating physician about their additional information, and felt that the physician accepted the information willingly. One JI male patient reported: *"My physician was glad to hear about innovations I read about, and she was happy that I am interested and that I want to learn more about my medical problem and treatment"*.

It appears that the five patients who did not want to answer this question were also hesitant about telling their physician about their search for more information, suggesting that patients tend to feel uncomfortable about telling their physicians they seek more information.

3.4.2.5 Willingness of patients to ask their physician questions

Out of thirty patients, only three reported not asking their treating physician questions, and only one felt that questions were not welcome by the physician. All other patients stated that they asked their treating physicians questions during their encounters. Most of the JI and AI patients who asked questions felt that the physicians have an obligation to answer questions, that they feel comfortable asking questions, and that they can ask whatever they feel is important for them to know. One expression was: *"It is the duty of the physician to explain and to answer, and it is my right to ask questions. It is my health and I want to know"*.

Time was found to be a limiting factor in asking questions. Five patients who reported asking questions, felt that physicians are short of time and are too busy to answer many questions, and therefore limited themselves in the number of questions they asked. An AI male patient said he only asked: *"What I think is really important, because physicians do not have the time to listen to endless questions, and one should not disturb them because they are very busy"*.

Eight FSU immigrant patients who reported asking questions mainly added that they limited the number of questions. Language barrier was an important reason for not asking many questions. Two female FSU immigrant patients and one female AI patient suffered from a language barrier, and had difficulties explaining to the physician what they wanted to know. They stated that when visiting language-concordant family physicians they were able to ask more questions.

3.4.2.6 Physician's attitude towards patient's questions asking

Question-asking was found to be very important to most patients in all three cultures. Twenty-seven patients reported asking questions, and twenty-six felt that their physicians accepted these questions willingly and cordially. A female FSU immigrant patient stated: *"Sometimes I am stressed and I ask questions nervously, and still the physician always answers nicely"*.

Four female patients claimed that their physician was reluctant to answer questions, and three patients complained about the physicians' attitude toward their asking questions. One patient felt that such impatience was due to the physician's lack of time. These findings may suggest that patients wanted to ask their physicians additional questions in order to receive more information. Most of the physicians complied with this desire to their patients' satisfaction.

3.4.3 Participatory decision-making (PDM)

3.4.3.1 Who should decide about patient's treatment?

Nineteen patients, including most of the FSU immigrant patients and the AI patients and half of the JI patients, chose to leave the decisions about their treatment to the physicians. The most common argument was their lack of medical knowledge. These patients felt that physicians have studied medicine as a profession and have acquired the relevant know-how. They did not feel they could take responsibility for making medical decisions that were beyond their expertise and understanding. A JI male patient said: *"The physician has the knowledge and the authority, and one should leave the decisions in his hands. What the doctor thinks is the right thing to do; this is what should be done"*. These patients expressed

trust in their physicians, and most of them thought that making medical decisions is part of the physicians' responsibility.

Two AI and two FSU immigrant patients thought they should be the ones to take the responsibility for decisions concerning their bodies and their health. They shared the need to consult with the physician, and to learn their physician's recommended preference, yet felt strongly that they themselves were responsible for decisions concerning their health. One expression was: *"The physician has the medical know-how, but this is my life, my body and therefore the final decision is in my hands and not in the physician's"*.

Seven patients, five JI and two AI patients, wanted to share the decisions with their physicians. They felt they should be involved in the process of decisions about issues that concern their bodies, health and future lives. They all valued the physicians' opinions, and choices; yet felt physicians should also take their opinions and feelings into account, consider their views, and accept them as partners in decision-making (DM). None of the FSU immigrant patients expressed a desire for PDM.

3.4.3.2 Who made the decision regarding medical treatment?

The results regarding who made treatment decisions showed congruence between patients' views and their actual experience concerning PDM. All nineteen patients who wanted to leave the decision to the physicians actually did so, and their physicians took the task upon themselves. The majority of FSU immigrant and AI patients, as well as half of the JI patients, left treatment decisions to their physician. These patients did not feel their physician had offered to share the decisions with them, and they did not feel the need to be part of the procedure. One AI male patient said: *"The physician made the decision, and if he would have asked me, I would have let him decide, because of his knowledge"*.

All these patients believed their lack of medical knowledge and trust in the physician left DM in the hands of their physician. They emphasized the desire for information, for asking questions, and for getting as many explanations as possible, yet did not wish to become partners in DM. Patients made a clear distinction between information-seeking, which they highly valued, and PDM, which they considered a burden they were reluctant to take upon themselves.

Four patients, two AI and two FSU immigrants, wanted to take responsibility for decisions, and reported that their physicians had agreed. They expressed a strong need to be responsible for decisions concerning their health, and all but one were satisfied with the physicians'

consent to accept their decisions. One AI patient felt nervous, because she believed that her physician saw her decision as an insult to his authority.

Only seven patients, five JI and two AI patients, reported to have actually shared decisions with their physicians, feeling they should be involved in decisions about issues that concern their health and future lives, and their physicians agreed to cooperate. An AI female patient said: *"I hear what the physician says, and I tell him what I feel, and although his opinion is more important, I want him to consider mine. I feel that we decided together on what is best for me"*.

These findings may suggest that patients who leave medical decisions to their physicians differentiate between two behaviours during the medical encounter. They seek information and are interested in getting as much information as possible from their physicians. They rely on this information offered by physicians, and ask questions to acquire additional medical information and increase their understanding. They do not, however, express an interest in PDM, and are reluctant to become active participants in making medical decisions affecting their well being. They trust their physicians, rely on their medical knowledge, and cast responsibility for DM on their physician.

3.4.3.3 Who is consulted with regard to treatment?

Four JI and three FSU immigrant patients did not feel the need to consult other sources. In addition, six AI patients did not turn to other sources. AI patients seemed more certain than their counterparts that medical issues are the sole responsibility of the physicians, and did not want to interfere with the physician's decisions. Six JI, seven FSU immigrant and four AI patients turned to other sources for additional consultations. Two JI patients who spoke to family members felt these conversations were related to information, not decisions. Two other JI patients, three other AI and six FSU immigrant patients turned to family members for advice. These results may be explained by patients' close familial ties, typical for the three culture groups, as addressed in the discussion (chapter 6).

Two AI and five FSU immigrant patients turned to language-concordant family physicians for further advice. Language barriers were found to be a limiting factor in patients' understanding of medical information provided by physicians. These barriers also limited patients' ability and willingness to ask questions during medical encounters with JI physicians.

All other sources to which patients turned were similar for the three cultures, and included friends and relatives who are physicians, medical books and publications, and the Internet. One FSU immigrant patient and three JI patients mentioned consulting a rabbi. Orthodox-

Jewish patients regularly bring their medical problems to their rabbi for advice, for referral to other physicians, and for spiritual support. One of them explained: *"Many people go to the rabbi as to a psychologist, for spiritual support"*. Muslim, Christian and Druze AI patients all said that they turn to their sheikh or priest only for prayer or spiritual support, but not for medical advice. They said: *"The priest is in the religion and the physician in the medicine"*, and *"You go to the sheik to pray for the success of an operation, but not for medical decisions"*.

3.4.4 Verbal communication

3.4.4.1 Language difficulties in meetings with physicians

None of the JI patients suffered from language barriers since all the physicians were Hebrew speaking. One of these patients asked for an interpreter when meeting with a FSU immigrant physician who had poor Hebrew proficiency. Two JI patients spoke about Russian-Israeli physicians' habit of speaking Russian in the presence of their patients while discussing their medical case, and felt stressed and anxious.

AI patients fluent in Hebrew had no difficulties when meeting with JI physicians. Nonetheless, most of them mentioned their Arabic-speaking family physicians, and thought they could better communicate with them, receive more information, and ask more questions. An AI female patient said: *"It is easier to see an Arabic speaking physician because I can make myself better understood"*. AI patients with poor Hebrew proficiency could not understand the physicians' explanations without the assistance of relatives or language-concordant medical staff.

Most of the FSU immigrant patients preferred meeting with Russian-speaking physicians, and reported having language difficulties with Hebrew-speaking physicians. They claimed they were unable to receive sufficient information, had difficulties in understanding the physicians and in making themselves understood, which affected their ability to ask their questions. These difficulties led to feelings of stress and uncertainty.

3.4.4.2 Translations during the medical encounter

Interpreters assisted eleven patients; three AI female patients, three male and four female FSU immigrant patients. AI and FSU immigrant patients with poor Hebrew proficiency reported they needed an interpreter, as they had difficulties in understanding what Hebrew-speaking physicians said. An AI female patient said: *"When I meet with an Israeli physician who does not speak Arabic, my husband translates for me, and sometimes a nurse or an Arabic-*

speaking physician joins the Israeli physician". Most of these patients received interpretation assistance from several sources: bilingual family members accompanying them, and available medical staff who were called in to translate.

3.4.4.3 Patient preference with regard to translators

AI and FSU immigrant patients who needed translation assistance shared the opinion that translation is a crucial requirement in medical encounters with language-nonconcordant physicians. They thought it most important to understand the physicians' explanations and questions, and to make themselves understood. They therefore emphasized the importance of a translator's presence and did not care who it was. They did not mind speaking of their medical problems in the presence of family members, because the goal of mutual understanding with the physician seemed to override any feeling of shyness. An AI female patient explained: *"It does not bother me who translates, medical staff, my family. A family member is even better. For the secrets of the body it is better to have the translation by someone from the family and not by a stranger"*. Only two female FSU immigrant patients did not want their sons to translate; one patient was embarrassed to reveal intimate matters in his presence, and the other did not want to burden her son with her problems.

3.4.4.4 Physicians' use of medical terminology

In most of the medical encounters, the physicians used medical terms or Latin words that the patients failed to understand. Most of the JI and FSU immigrant patients reporting such encounters felt uncomfortable asking for clarifications. They identified several reasons, such as being embarrassed that physicians would know they failed to understand, and hesitation to take more of the physicians' time. An AI male patient said: *"Some physicians let Latin medical terms slip into the conversation, which I don't understand. Sometimes I catch a word and ask, but mostly I am embarrassed, and I also feel that there is not enough time for the physician to explain every word"*.

Some of these patients thought that physicians have their own professional language that does not concern the patients, or that the general meaning of the information is important, and not the isolated word. A few patients felt angry, and thought that it was the physicians' obligation to clarify all the details of the information, yet other patients reported that their physicians willingly explained terms they failed to understand. Several patients noticed that physicians tend to use medical terminology when speaking with each other, and complained about their habit to do so in the presence of their patients. An AI male patient reported: *"Physicians who use medical terminology are a problem. It aggravates and annoys me. They speak among*

themselves in unclear terms in my presence, and mostly they are reluctant to answer when I ask. I think it is my right to know everything about my problem, and it is their obligation to clarify unclear terminology". These patients felt this behaviour caused them to feel anxious and worried that the physicians were discussing matters they were reluctant to reveal to the patients.

3.4.5 Time as a factor in the medical encounter

Fifteen patients reported to have spent enough time with their physicians. Some of them thought that physicians are always busy, and therefore they should not take more of their time, so they asked only the questions that were really important. The patients who complained of shortage of time were troubled and stressed. They all shared the feeling that the information they received was insufficient, that they were denied the opportunity to ask all the questions they wanted to ask, and that the atmosphere of the encounters was unpleasant. A JI male patient said: *"If we had had more time, the physician would have explained the problem in a more detailed way, and what it means from my point of view. This could have eased my feelings of uncertainty"*.

AI and FSU immigrant patients mentioned their desire to befriend their physicians. They spoke of the need to learn to know each other before getting into the medical details of the meeting. They wanted to feel that the physicians really cared about them as people, and wanted to share their personal problems with their physicians. They felt they were unable to do so because the physicians did not allocate enough time and limited themselves to the medical aspects of the visit.

Two JI, four AI and eight FSU immigrant patients felt the need to consult family physicians. They all spoke of their personal relations with the family physician, and about the longer and friendlier visits, in which they also received more information, and had the chance to ask more questions, improving their understanding of the medical problems and treatment. An AI male patient felt: *"With him I can speak longer, and discuss personal things before we get into the medical details, which serves as an introduction to the visit and has a calming effect"*.

3.4.6 Physician's interpersonal communication

3.4.6.1 Desire to discuss personal issues

Those patients who expressed a wish for personal discussions with their physicians gave several reasons. They thought that disclosure of personal matters enables physicians to learn

to know them, and to better understand how these problems affect their medical condition. A JI female patient thought: *"It is not a must, but I think a physician should want to learn to know his patient in a way that will contribute to his understanding of the person behind the disease"*.

Most AI and several JI patients wanted to befriend the physician, feeling that friendly relations would create a good atmosphere, and would encourage them to speak more freely about their medical problems. AI and FSU immigrant patients felt that private and personal problems could be more easily and openly discussed with language-concordant physicians, mainly their family physicians. An AI female patient spoke of her Arabic-speaking family physician: *"With him I can talk about private things and about things that happen at home. He knows me well, and he is like a friend, a brother, and I can tell him a lot, which is good for me"*.

The patients who did not wish to discuss personal matters thought it was not the physicians' obligation to get into such conversations. They felt that physicians were busy and should concentrate on treating medical problems. FSU immigrant patients emphasized the shortage of time, and felt that such discussions could only take place if the physicians dedicate the needed time. AI and FSU immigrant patients felt that if they were to discuss personal issues at all, they could only respond to language-concordant physicians who would initiate such conversations.

3.4.6.2 Raising personal issues and the physician's response

Most of the twelve patients who wanted to speak about personal matters said that their physicians initiated the conversation, and that they willingly accepted the opportunity. They all felt that personal conversations added to their trust and satisfaction with the physician, and improved the atmosphere of the visits. They regarded the physician's attitude as friendly, caring and understanding. Only two of these patients were JI.

AI and FSU immigrant patients seemed more interested in personal conversations than JI patients. AI patients wished to become friendly with the physician to get to know one another, and wanted to have a personal discussion as a preface to the meeting in order to create a pleasant atmosphere before getting into the medical details of their problems. An AI male patient said: *"The physician started with a general discussion and we spoke of several things. This created a comfortable atmosphere, and I felt that the physician is first of all a person like me. We were like two equal people, and not like I am the doctor and you are the patient. This gave me a good feeling and I was confident that he could help me"*. FSU immigrant patients

longed to speak about their absorption problems and the difficulties of their daily life. They were encouraged to do so, on the physicians' initiative. A female patient said: *"I knew he was busy, but I was glad that he asked, and I felt good telling him about my worries and thoughts"*.

JI patients seemed more practical about their visits, and did not think there was either a need for personal discussions or sufficient time for them to take place. The initiative for personal discussions was mostly left to the physicians. A JI female patient felt: *"Physicians don't have enough time, and therefore I do not have the opportunity to speak about private things. If it were possible, I would have wanted to tell my physician. It would have added to the atmosphere, and minimized uncertainties"*.

The patients who did not speak about personal matters gave several reasons. Most of them said the physicians did not initiate such conversations, and therefore they did not feel free to take the initiative; they mentioned physicians' lack of time as a limiting factor. Physicians cut the visits short, and patients felt they could not speak about problems other than medical ones. A few patients did not think personal conversations with the treating physicians were necessary at all, and therefore limited the conversations only to the medical problems they had come for.

3.4.6.3 Physician's friendliness and humour and their impact on the encounter

Twenty-five patients reported that their physicians were friendly, and all thought that the physician's friendly approach created a good and pleasant atmosphere during the encounter. They felt reassured that physicians really cared about them and calmed them. The patients that reported about physicians with a sense of humour were very pleased, and found that this humour improved their mood and added to the pleasant atmosphere. A JI female patient said: *"My physician is very friendly, he smiles a lot, and jokes with me, and I really like it. It is not enough for a physician to have knowledge. Human relations are worth millions. A courteous physician brings happiness to his patient's heart"*.

Five patients felt that their physicians were unfriendly and complained about the atmosphere during the medical encounter. They mentioned physicians who were short of time, strict and uninterested. An AI female patient complained: *"He was not interested in me as a person, and I was stressed. He did not say anything which was friendly or nice and I longed so much to tell him about my problems, but I could not"*.

FSU immigrant patients spoke of their friendly, Russian-speaking family physicians, and unfavourably compared the Israeli treating physicians to the friendly physicians they had

known in Russia. One expression was: *"The physician was strict, like most physicians here, and I was unhappy about it, because in Russia they were friendly, and that calmed me".*

3.4.7 Gender

3.4.7.1 Differences between male and female physicians and patient preferences

Three JI, six AI, and four FSU immigrant patients described differences between male and female physicians. Both male and female patients felt that female physicians tend to be more gentle, pleasant and patient with their patients. An AI male patient described a visit with a female physician: *"Female physicians, in my experience, are more sensitive than male physicians. I met with a female physician who was gentle and considerate. She was patient and explained everything I wanted to know step by step, so that I could follow her thoughts. The visit was very pleasant".*

Some patients did not like to be examined physically by physicians of the opposite sex; female patients were embarrassed to have intimate examinations by male physicians, and several male patients, especially those who were religious, did not like being physically examined by female physicians. All but one female patient thought that male and female physicians do not differ in their professional knowledge and skills. This one female patient (FSU immigrant) did not criticize female physician's know-how, but thought that female physicians, like all women, are preoccupied with domestic duties and some of their attention is drawn away from their work.

All JI patients expressed no preferences about their physician's gender. Two male AI, and three FSU immigrant patients (two male and one female) preferred male physicians. Two female AI and one female FSU immigrant patients preferred female physicians. The main reason for their preference was their reluctance to be physically examined by a physician of the opposite sex. All twenty-four patients who did not express any preference identified similar qualities they looked for in their physician regardless of the physician's gender. They sought compassionate relations and a kind and caring attitude towards patients, professional skill and knowledge, and sufficient time. An AI male patient thought: *"A physician is a physician, the main point is that they should be good professionally and kind".*

3.4.7.2 Gender preference in discussion of personal issues

Eight JI and seven FSU immigrant patients did not differentiate between male and female physicians with regard to personal conversations. They agreed that it was not the physician's gender that counts, but rather the personality and the courteous and pleasant attitude that

made the difference. A JI female patient said: *"I don't think that a female physician is more open or friendly than a male. My physician is a male, he is friendly and kind, and I can tell him everything".*

Seven patients felt more comfortable speaking with female physicians about personal and emotional issues. These included two JI males, three AI males and one AI female, and one FSU immigrant female. Their arguments were that female physicians are friendly, sensitive, patient and kind. The female patients were also embarrassed and felt uncomfortable telling a male physician about personal and intimate concerns. An AI female patient said: *"I think a female physician will show more identification with me as a patient. I can tell her more, because she is a woman like me, and women better understand each other".*

One AI patient spoke to her male physician about personal matters, mainly because he spoke Arabic and because he initiated the conversation in a friendly manner. One male FSU immigrant patient said he was very reserved, and if at all, he could only speak about such matters to a male physician. Seven patients did not want to initiate personal conversations, and four of them did not want to speak about personal issues with their physician regardless of gender.

JI and FSU immigrant patients seemed more at ease speaking about personal issues with their physicians than AI patients. AI patients seemed more reserved, and were either reluctant to speak about personal matters with their physicians at all, or preferred female physicians. The physician's personal relationships, friendliness and compassionate attitude were the main reasons for patients' disclosure of personal matters, rather than physicians' gender.

3.4.8 The "Ideal" physician

3.4.8.1 Choosing what is most important in relations with the physician

All thirty patients identified as important the same six aspects of the medical encounter and mentioned similar reasons for their opinions: information disclosure and question answering; physician's personal and compassionate attitude; physician's professional knowledge combined with humane approach; sufficient time offered by physician; overcoming language difficulties; participatory decision-making.

There were, however, some variations in emphasis among the three groups of patients with regard to the importance of each aspect. Information-seeking and-giving was considered highly important to better understand the patient's medical problems and their suggested treatment. By giving detailed information and answering questions, physicians were believed

to create trust and to calm patients' worries and uncertainties. A JI female patient said: *"The ideal physician should volunteer the information, initiate these explanations for the patients, and patients should be able to ask all their questions. Physician should be open and tolerant to the patient's need for information"*. Most of the JI patients emphasized this aspect, compared to less than half the AI and FSU immigrant patients.

The physician's personal and compassionate attitude was considered crucial for twenty-four patients, and this issue aroused considerable emotion. They all agreed that positive personal relations improved the atmosphere of the encounter and made patients feel that their physician cared about them as human beings. Patients of the three cultures used the term *"ben adam"* to describe a humane and caring physician. An AI female patient said: *"let him first of all be a human being, feel the patient's pain"*. Among the AI patients there was an additional wish to befriend the physician. They felt if they got to know one another, they would be able to feel more comfortable in disclosing personal and medical information.

The combination of professional knowledge and a humane approach was considered ideal among all three patient groups. Although patients wanted to be seen by specialized and professional physicians and valued their medical competence, they stressed the importance of the physician's personal relations. They emphasized that professional knowledge by itself was insufficient. A smile or a good word from the physician was believed to contribute to the patient's well being and recovery. A female FSU immigrant patient felt: *"Some physicians are professional, but you feel that they treat you like air. They do not pay attention to you, they seem to hear and not hear you, and this is very difficult. A physician should know his profession well, but he must be a ben adam"*.

Lack of time was mentioned as a limiting factor in receiving and understanding medical information. Patients wished to spend more time with physicians in order to ask all their questions and clarify information and instructions for treatment. Lack of time was thought to negatively affect the encounter's atmosphere and to create stress. JI patients correlated shortage of time mainly with insufficient information, while AI and FSU immigrant patients were more concerned with shortage of time as a factor in preventing the establishment of friendly relations with the physician. A female FSU immigrant patient said: *"when there is time, we can speak of personal things, and the atmosphere improves and the relations become more personal"*.

Overcoming language difficulties was an issue for AI and FSU immigrant patients with limited Hebrew proficiency, who expressed the desire to meet with language-concordant physicians for several reasons. Verbal communication with language-concordant physicians

enabled patients to better understand medical information, helped them disclose their medical history and ask questions. They felt comfortable creating friendships and disclosing personal matters with language-concordant physicians, who also spent more time with them and paid more attention to their worries. A female FSU immigrant patient explained: *"It is difficult to ask questions when you don't speak the language well, to verbalize your thoughts. With a Russian-speaking physician I can speak about details, ask questions, and better understand the issues".*

Only five patients; one JI male and one female, one AI male and one female, and one male FSU immigrant, mentioned PDM with physicians as an important aspect in their relations. They made a connection between information-giving by physicians and allowing for mutual DM. They wanted to receive detailed information and explanations, which made them feel that the physicians' recommendations for treatment were based on profound knowledge. In order to strengthen their trust in the physician, they wished for mutual DM based on the provided information. One patient claimed that making decisions mutually was an ideal process, but that he had never come across a physician who was willing to give up his authority.

3.5 Summary

The main goal of the in-depth interviews was to discover how patients value the interaction with their physician during a medical encounter, and to provide further understanding of patients' attitudes, needs and expectations from this meeting.

At the end of each in-depth interview, patients were asked to describe the desired characteristics of a medical caregiver, and what aspects they valued as contributing to a successful encounter. All thirty patients identified the same aspects of the encounter as being important: information-giving and question answering; physician's personal and humane attitude; physician's professional knowledge combined with a humane approach; time offered; overcoming language difficulties; and participatory decision-making. These aspects correspond to the predetermined aspects identified for the field study. One may argue that patients concentrated on topics that had been discussed in detail throughout the interviews, and that these naturally emerged in summarizing the interviews. However, the extent of patients' emotional involvement in these issues is believed to indicate their profound identification with these aspects.

Information-giving by physicians was highly valued by patients; all expressed both a desire and a need for information. Physicians who provided detailed information and answered

questions were believed to strengthen patients' trust, assuage their worries and uncertainties, and indeed fulfil their obligations to the patient. The desire for information ran through the interviews as an ongoing theme. Indeed, the degree of understanding or misunderstanding of medical information affected patients' experiences concerning other aspects of the medical encounter, such as problems deriving from language barriers and lack of time, as well as their participation in decisions concerning their treatment. Physicians' willingness to provide detailed information and to engage in question answering was an important criterion in judging their professional skills, courtesy and desired characteristics. AI and FSU immigrant patients were found to seek further information from language-concordant family physicians, who were perceived as easier to communicate with and more willing to listen.

The patient-centred or patient autonomy model of physician-patient relations includes sharing information with patients and permitting them to state preferences about treatment options during the encounter. Patients who wished to receive detailed information were expected to participate actively with their physicians in making treatment decisions. Yet most patients chose to leave decisions to the physician, and did not include sharing decisions as part of their image of desirable future encounters. The majority of AI and FSU immigrant patients, and half of the JI patients, felt they could not take responsibility for making medical decisions that would influence their future health and well-being. The most common argument was their lack of medical knowledge, in contrast to the physician's professional expertise and experience.

Most patients shared the opinion that physicians suffer from shortage of time. Sufficient time was emphasized as a necessity and as desirable in their image of future visits. Some patients seemed to understand that physicians are always busy and have many patients to attend to; still, they all felt they deserved more time with their physicians. Short visits were believed to negatively affect the encounter's atmosphere, to limit patients' knowledge and understanding of medical problems and treatment, and to curtail question asking and answering. AI female patients and FSU immigrants reported that language-concordant physicians dedicate more time to encounters, provide more detailed information, answer more questions and establish personal and friendly relations.

Language barriers created several problems for AI and FSU immigrant patients who had poor Hebrew proficiency; these barriers were identified as a crucial factor throughout the interviews. Patients linked language barriers to physician's communication style, information-giving and question answering, as well as time. AI patients with poor Hebrew proficiency could not understand the physicians' explanations without assistance from their relatives or language-concordant medical staff. Most of the FSU immigrant patients preferred meeting

with Russian-speaking physicians. AI and FSU immigrant patients who needed translation assistance shared the opinion that translation is an essential requirement in medical encounters with language-nonconcordant physicians. All but two patients did not mind speaking of their medical problems in the presence of family members; the goal of mutual understanding seemed to override any feeling of embarrassment. Most patients encountered physicians who used medical terminology that they failed to understand. Some patients felt irritated and worried that the physicians were using this terminology to obscure matters they were reluctant to reveal.

Physician gender was not emphasized in patients' preferences. Patients identified the virtues they desired in their physicians, regardless of gender. These included humane relations and a kind and caring attitude, professional skill and knowledge, and sufficient time. They found no differences between male and female physicians with regard to their professional knowledge and skills. Nevertheless, some male and female patients felt that female physicians tend to be more gentle, patient and pleasant than male physicians. Several patients did not like being physically examined by physicians of the opposite sex; female patients were embarrassed to have intimate examinations by male physicians, and several male patients did not wish to be physically examined by a female physician, mainly for religious reasons.

The physician's communication style, whether friendly or unpleasant, deeply affected patients' memories of past encounters. A personal and humane attitude on the part of the physician was considered a crucial aspect of physician conduct. The desire to be recognized as unique human beings has been emphasized by Mishler (1984), who applied Habermas' theory of Communicative Action. This theory posits a dialectical struggle between value rationality, which inhabits the lifeworld, and purposive rationality, which inhabits the system. Mishler applied this concept specifically to the struggle between the voice of medicine and the voice of the lifeworld, that is, the patient's contextually-grounded experiences of events and problems. He claimed that any medical encounter without the voice of lifeworld was inhumane and ineffective, drawing attention to the central importance of treating the whole person and respecting one's humanity. Barry (2001) found support for the premise that increased use of the lifeworld makes for better outcomes and more humane treatment of patients.

The patients interviewed in-depth related the physician's personal and humane attitude to almost every other aspect of the physician-patient relationship. They expressed a desire to establish relations of friendship with their physicians and to be able to entrust physicians with information on private and personal issues. They longed to meet with friendly physicians who gave the impression they really cared about their patients' medical and personal problems.

Information-giving, question answering and PDM were perceived as dependent upon the physician's willingness and initiation. Insufficient time devoted by physicians and language barriers negatively influenced the atmosphere of the encounters and led to frustration and anxiety. A good word or a smile on the part of physicians was believed to provide added value to any medicine and treatment. The following statement by a patient, who was very emotional about this aspect, seems to best summarize patient feelings and desires: *"The physician should have more heart for his patients, let him first of all be a 'ben adam'* (a human being)!"

Chapter 4 Methodology of study

The study was conducted in the outpatient clinics of the following departments and services at the Bnai Zion Medical Centre in Haifa: Internal Medicine, Liver Diseases Service, Lung Diseases Service, Nephrology, Clinical Immunology, Endocrinology, Cardiology, Rheumatology, Orthopaedics, Neurology, E.N.T., Urology, Gastroenterology, Angiology, Pre-Operative Clinic, and Rehabilitation. Patients were randomly assigned to an available physician according to routine clinic procedures.

4.1 The questionnaire

The study's main research tool was an Attitude and Satisfaction Questionnaire concerning the medical encounter. The questionnaire consisted of three parts:

(1) The first part was the Informed Consent Form, which the patients were asked to sign at the beginning of the interview.

(2) The second part included demographic information, such as date of birth, country of birth, year of immigration, marital status, religion, and information about the medical encounter, such as the language of the encounter and who translated during the encounter.

(3) The third part contained forty six statements related to different aspects of patient attitudes and satisfaction with variables of the physician's communication during the medical encounter.

Patients were asked to respond to each statement on a five-point Likert scale, ranging from "totally disagree" (scored as 1) to "agree totally" (scored as 5). Scale items were balanced in terms of positively and negatively worded items, to reduce acquiescent response bias (Ware 1978). Four questions concerning patients' preferences were presented separately, and patients indicated their answers by marking yes/no boxes.

4.1.1 Development of the questionnaire

The questionnaire was pre-tested twice. The first version of the questionnaire (Appendix C1) was tested on forty-five patients. Thirty in-depth interviews were then conducted with additional thirty patients, ten patients from each of the three cultures: Jewish-Israeli (JI), Arab-Israeli (AI), and immigrants from the former Soviet Union (FSU). The results of these two stages served to produce the revised version of the questionnaire (Appendix C2). The

revised version of the questionnaire was tested on fifty-four patients, and served as the basis for the field study.

On both pre-tests, the questionnaire statements were divided a priori into seven sub-scales (Appendix D).

4.1.2 Pre-test No. 1

The questionnaire used in Pre-test No.1 consisted of three parts. (1) The first part was the Informed Consent Form, which the patient was asked to sign at the beginning of the interview. (2) The second part included demographic information, and information about the medical encounter. (3) The third part of the questionnaire contained 48 statements, which the patient was asked to grade on a 5-point Likert scale. The questionnaire was tested as a pilot on forty-five patients: fifteen Jewish-Israelis (JI), fifteen Arab-Israelis (AI) and fifteen immigrant patients from the former Soviet Union (FSU), at the internal medicine outpatient clinics of the Bnai-Zion Medical Centre in Haifa. Language-concordant interviewers approached each patient in the patient's mother tongue, and after receiving the patient's consent, sat with the patients until they completed the questionnaires. After data collection was completed, the questionnaires were processed by statistical software for Windows (SPSS).

All forty-eight statements on the questionnaire were divided into seven categorical sub-scales, determined a priori by the researcher:

a. Information.
b. Participatory decision-making (PDM).
c. Verbal communication.
d. Time.
e. Physician's interpersonal communication.
f. Gender.
g. Overall satisfaction.

Chronbach's alpha was calculated for each sub-scale. All sub-scales showed alpha larger than 0.63, except for one (PDM), which showed alpha=0.47. For all sub-scales a measure of "alpha if item deleted" was calculated, and the frequency distribution was calculated for each individual statement (appendix E).

The alpha coefficient, alpha if item deleted, and frequency distribution served as a criterion for excluding statements from the questionnaire. Those statements which showed over 90% of

identical answers were examined. Three statements were omitted for lack of differentiation, as follows:

a. Statement No. 27: "Sometimes the doctor talked down on me" (93% of agreement).
b. Statement No. 32: "The doctor clearly explained my medical condition" (89% of agreement).
c. Statement No. 40: "The doctor listened carefully to everything I said" (91% of agreement).

Eleven statements that exhibited over 90% of identical answers, or that were marked by patients as not well understood, were not omitted, as they were considered essential in content for the study; therefore, they were rephrased (Appendix F).

In the first pre-test of the questionnaire, patients were found not to differentiate between "totally disagree" (marked as 1), and "irrelevant" (marked as 0). The grade 0 was originally introduced mainly for statements concerning language and translation problems, which were applicable for AI and FSU immigrant patients. The grade 0 was omitted, and these statements were separated and transferred to the end of the questionnaire, to be answered only by those patients who suffered from language and interpretation problems during the medical encounter.

The first two parts of the questionnaire remained unchanged. The third part, which contained forty eight statements, was divided in the revised version of the questionnaire into three units:

a. Thirty-six statements, which patients were asked to grade on a 5-point Likert scale.
b. Four statements, which were rephrased, were no longer graded on the 5-point Likert scale. The patients were asked to answer these statements by marking boxes.
c. Four statements, graded on a 5-point Likert scale, concerned only patients who suffered from language and translation problems during the medical encounter.

Table 1: *Pre-Test 1—Reliability coefficients (Cronbach's alpha) for each sub-scale*

Sub-scale name	Items	Cronbach's alpha coefficient
Information-giving and seeking	1, 2, 5, 10, 13, 17, 21, 23, 33, 39,	0.63
Participatory decision-making	4, 14, 18, 22, 25, 28, 31	0.47
Verbal communication	6, 15, 19, 40, 41, 42, 43	0.90
Time	9, 16, 20, 27, 32	0.66
Physicians' interpersonal communication	3, 7, 11, 24, 29, 30, 34, 36	0.70

4.1.3 Pre-test No. 2

The revised version of the questionnaire was tested as a pilot on fifty-four patients (six patients from each of the nine groups), at the outpatient medical clinics of the Bnai-Zion Medical Centre in Haifa. Language-concordant interviewers approached each patient in the patient's mother tongue and asked the patient to participate in the research. Those patients who agreed signed the Informed Consent Form and filled out the questionnaires in the presence of the interviewers. After data collection was completed, the questionnaires were processed using statistical software for Windows (SPSS). All forty-four statements of the questionnaire were divided into seven categorical subscales, which were determined a priori by the researcher, as in the first pre-test. Chronbach's alpha was calculated for four subscales:

a. Information
b. Participatory decision-making
c. Time
d. Physician's interpersonal communication

All groups showed alpha larger than 0.57.

Four out of seven questions concerning language barriers and interpretation were separated in the revised version of the questionnaire, to be answered only by patients who experienced problems deriving from language barriers during the encounter. As the sample did not include a sufficient number patients with language problems (eighteen patients visited language-concordant physicians), alpha coefficient was not calculated for the verbal communication sub-scale. The results of the gender sub-scale were not examined, as these statements are concerned with patient preferences rather than with attitudes, and therefore were relevant for the final outcomes of the field research.

Table 2: *Pre-Test 2—Reliability coefficients (Cronbach's alpha) for each sub-scale*

Sub-scale name	Items	Cronbach's alpha coefficient
		Pre-test No.2
Information-giving and seeking	1, 2, 5, 10, 13, 17, 21, 23, 33, 39,	0.78
Participatory decision-making	4, 14, 18, 22, 25, 28, 31	0.57
Verbal communication	6, 15, 19, 40, 41, 42, 43	(not calculated)
Time	9, 16, 20, 27, 32	0.85
Physician's interpersonal communication	3, 7, 11, 24, 29, 30, 34, 36	0.73

Statement No. 9: "I would prefer to be examined by a doctor who speaks my language", was rephrased to: "I prefer to be examined by a doctor who speaks my language". The new version enabled patients in all nine groups to address this question, which is concerned with patient preferences. The first version was more suitable for patients of culture-incongruent dyads.

When the revised version of the questionnaire was tested, it was discovered that the availability of Arab-Israeli and Russian-Israeli physicians in the internal medicine outpatient clinics of the Bnai-Zion Medical Centre was insufficient for the purposes of the field research, as most treating physicians in these clinics are Jewish-Israeli. In order to avoid the potential bias that may occur if the same physicians were to examine all the patients of a particular group, it was considered necessary to increase the number of participating physicians from all three culture groups. To include a larger number of AI and Russian-Israeli physicians in the field study, data collection was expanded to a larger range of clinics. The researcher personally approached the heads of all the departments and units who run outpatient clinics at the Bnai-Zion Medical Centre, and received their permission to include physicians and patients from their clinics in the study. The field study was therefore expanded to encompass the following clinics: Internal Medicine, Liver Diseases Service, Lung Diseases Service, Nephrology, Clinical Immunology, Endocrinology, Cardiology, Rheumatology, Orthopaedics, Neurology, E.N.T., Urology, Gastroenterology, Angiology, Pre-operative Clinic, and Rehabilitation.

4.1.4 Reliability and Validity

Quantitative research requires examining the reliability and validity of the research instrument. Reliability refers to the degree of consistency and stability of the results collected by the research tools. Validity refers to the ability of the research tool to gather information about the concept it claims to be measuring.

The current study's main research tool was an attitude and satisfaction questionnaire. The questionnaire was written in Hebrew and examined by a professional statistician who specializes in research methods and in the methodology of questionnaire writing.

Translation and back-translation provided face validity of the translated questionnaire. The questionnaire was translated into Arabic and Russian by two professional translators and then back translated by a second set of professional translators. The two versions of the original questionnaire were checked for accuracy and adequacy of translation by a third set of professional translators, who specialize in medical and legal translations. Special attention

was directed to equivalence of concepts and meaning in the three languages. The original English version and the back translated version were also compared for adequacy.

The methods chosen for examining reliability and validity are compatible for examination of questionnaires.

4.1.4.1 Reliability

Internal consistency is the main type of reliability used for questionnaires. This technique involves testing for homogeneity within a group of items, and the extent to which these items (statements) relate to a particular dimension on a scale and to no other. Since the study pre-tested the questionnaire twice prior to the field study, the internal consistency was tested three times, yielding similar results.

The calculations of Cronbach's alpha indicated a high internal consistency level, usually greater than 0.77 in the field study, for the combined scales.

4.1.4.2 Validity

Face validity and content validity were examined.

Face validity refers to subjective assessments of the presentation and relevance of the questionnaire (Bowling 1999). Two sociological experts examined the relevance, potential ambiguity and clearness of the questionnaire's statements. In addition, the respondents on the two pre-tests were asked to comment on statements that seemed unclear or ambiguous. In accordance with comments by the experts and the patients, several statements were revised (see pre-test 1 and 2). As described above, the translation and back-translation procedure also served to examine the face validity of the questionnaire.

Content validity refers to judgements about the extent to which the content of the instrument appears to examine and comprehensively include the full scope of the domain it is intended to measure (Bowling 1999). An extensive literature review was carried out to achieve content validity. This review included thorough investigation and analysis of theoretical aspects reflecting the processes and behaviours found to dominate physician-patient relations.

The questionnaire was specially designed by the researcher, and examined by the same sociological experts, in order to encompass aspects that emerged from the literature review. After these aspects were defined, and based on the experts' evaluation, some statements were rephrased, added or omitted. In addition, thirty personal in-depth interviews were conducted after the first pre-test of the questionnaire. All thirty patients identified the same aspects of the

encounter, chosen a priori for the interview (and the questionnaire), as being of most importance. The extent of patients' identification with these issues served to strengthen the decision to select these aspects for the main study.

The study's sample included medical patients. The ethical considerations demanded by the Bnai Zion Medical Centre's Helsinki ethical committee with regard to respect for patient privacy and anonymity prevented the researcher from using additional evaluation tools, such as observations or videotaping of the encounters. Therefore, examination of the construct validity through correlation testing was not applicable.

4.1.5 Definitions for questionnaire's sub-scales:

a. Information-giving and seeking: Addresses patients' attitudes and needs towards information-seeking behaviours, and their evaluation of the physician's information-giving behaviour. A high score indicates patients' increased information-seeking behaviour and a higher degree of physicians' provision of information.

b. Participatory decision-making (PDM)- Addresses patients' desire to participate in decision-making concerning their options and treatment. A high score indicates patients' increased desire for participation.

c. Verbal communication - Addresses patients' problems deriving from language barriers, interpretation, and physicians' use of medical terminology. A high score indicates increased patient language problems.

d. Time - Addresses patients' satisfaction with time spent with physicians. A high score indicates patients' feelings of shortage of time and desire for more time.

e. Physician's interpersonal communication - Addresses patients' evaluation of physicians' behaviours establishing positive and affective communication. A high score indicates patients' increased positive evaluation of physician courtesy and rapport.

f. Gender - Addresses patients' preferences regarding their physicians' gender.

4.1.6 Field Study

The questionnaire's statements were divided into sub-scales based on the results of the two questionnaire pre-tests. Modifications in the sub-scales were made according to the reliability of the revised sub-scales. Another sub-scale was added, consulting with others, which

included questions 13,18,25,31 that were separated from the a-priori determined sub-scale of participatory decision-making. This sub-scale is defined as follows:

g. Consulting with others- explores patient attitudes and needs regarding further information-seeking and decision-making behaviours concerning their medical condition and suggested treatment. These statements were later also separated to explore the identity of patient consultants, such as relatives, friends and members of the clergy.

Questions 4, 6, 12, 26, 32, 35, 40, were analyzed separately as individual items, since their reliability to other sub-scales was low.

Table 3: *Reliability coefficients (Cronbach's alpha) for each sub-scale - Field study*

Sub-scale	Statements	Cronbach's alpha coefficient Field Study
Information-giving and seeking	1,2,5,10,-21, 23,28,33	0.84
Participatory decision-making	-8,14,22	0.77
Verbal communication	-15,19,41,42, 43,44	0.86
Time	-9,16,20,27, 36	0.89
Physician's interpersonal communication	3,7,11,17,24, 29,30,34	0.84
Consulting with others	13,18,25,31	0.53
Gender	37,38,39	*

* Questions of preference (yes/no) were not calculated - Reversed items

4.2 Sample recruitment and procedures for field study

4.2.1 Sample size

The study required multivariate statistical analyses (MANOVA). This type of analysis demands special computation of required sample size, which takes into account several factors: effect size, test power, size of type I error (alpha), number of groups compared, number of dependent factors (subscales in the questionnaire). Therefore, the standard formula

of sample size was not considered adequate. Taking into account all the above factors, Stevens (1986) tables of sample for MANOVA analysis were adopted. According to these tables, the recommended sample size-with power of 0.90, moderate size effect, difference of at least 0.75 between groups (on a Likert scale), and type I error = 0.05, 6 groups and 6 subscales- is 110 subjects per group. The target sample contacted 110 patients in every one of the nine groups, for a total of 990 patients.

4.2.2 Patient sample

The patient sample consisted of adult patients seen in the outpatient clinics. The study comprised nine groups, categorized by the combinations of the cultures of the physician-patient dyads. Three comparison groups were comprised of culture-congruent physicians and patients: Jewish-Israeli (JI), Arab-Israeli (AI), and Russian-Israeli physicians seeing culture-congruent JI, AI, and FSU immigrant patients. Six groups were culture-incongruent: JI physicians and AI patients, JI physicians and FSU immigrant patients, AI physicians and JI patients, AI physicians and FSU immigrant patients, Russian-Israeli physicians and JI patients, Russian-Israeli physicians and AI patients.

A total of 1079 patients were approached by the interviewers. The target sample included 110 patients in every one of the nine groups, for a total of 990 patients (91.8%). 89 patients (8.2%) refused to participate in the study.

4.2.3 Sample recruitment

The research population consisted of patients invited and referred to the various outpatient clinics during eight months in 2003. All patients were interviewed individually by specially trained interviewers. Two JI, three AI and three FSU immigrant interviewers were recruited and trained for the field study. The interviewers waited for the patients in the waiting rooms, outside the examining rooms. As the patients left the examining rooms, the interviewers approached them and checked whether they were eligible for the target sample. Those patients who were found eligible were given a short explanation about the study, and were asked to participate. Those who agreed were presented with the questionnaire and an informed consent form, which they were asked to sign. Because patients were promised confidentiality of their answers, the signed informed consent forms were separated from the questionnaires in the presence of the patients, and inserted into a special box. All patients were given the opportunity to answer the questionnaire in their mother tongue, Hebrew, Arabic or Russian.

Each patient answered the questionnaire in the presence of a language-concordant interviewer. Assistance in completing the questionnaire was provided by the interviewer when necessary. This assistance usually involved reading the questions out loud to patients, upon request. The interviewers were instructed to assist patients in understanding the questions only if the patients requested clarification, and to avoid suggesting any answers. Patients who were accompanied by family members or other escorts were asked to fill out the questionnaires on their own, and not to consult the accompanying person. The interviewers tried as much as possible to isolate the interviewees from the other patients who were waiting at the same waiting areas.

4.2.4 Sample inclusion criteria

All patients of each participating physician were eligible if they met the following criteria:

a. Male and female patients from the three relevant cultures who agreed to participate in the study:

   Jewish-Israeli patient: Every patient born in Israel before 1982 or who immigrated to Israel before 1982, i.e., patients living in Israel for at least 20 years.

   Arab-Israeli patient: Every Arab patient holding Israeli citizenship.

   Immigrant patient from the former Soviet Union: Every patient who immigrated to Israel from the former Soviet Union after 1988.

b. Adult patients at least 21 years old.

4.2.5 Inclusion criteria for participating physicians

The patients in the participating outpatient clinics were examined by forty-three male and thirteen female physicians: thirty-three Jewish-Israeli, ten Arab-Israeli, and thirteen Russian-Israeli physicians. All physicians were specialized professionals, and board certified in their medical fields.

Jewish-Israeli physician: Every physician who was born in Israel or who immigrated to Israel before 1982, excluding physicians from the former Soviet Union.

Arab-Israeli physician: Every Arab-Israeli physician holding Israeli citizenship.

Russian-Israeli physician: All physicians who graduated from medical school in the former Soviet Union.

Chapter 5 Results

This chapter describes the characteristics of the patient sample, examines the study's hypotheses, and presents the results of the multiple regressions as well as additional data results.

5.1 Sample description

Table1 describes the sample of 990 patients who participated in the field study.

Table 1: *Sample description*

Patient culture		Jewish-Israeli		Arab-Israeli		FSU immigrants		Total		
		n	%	n	%	n	%			χ^2
Patient gender	Male	165	50.0%	165	50.0%	165	50.0%	495	50.0%	
	Female	165	50.0%	165	50.0%	165	50.0%	495	50.0%	0.00
Total		330	100.0%	330	100.0%	330	100.0%	990	100.0%	
Marital status	Single	58	17.6%	60	18.2%	40	12.1%	158	16.0%	.
	Married	212	64.2%	256	77.6%	213	64.5%	681	68.8%	
	Divorced / Separated	23	7.0%	6	1.8%	43	13.0%	72	7.3%	64.14***
	Widowed	37	11.2%	8	2.4%	34	10.3%	79	8.0%	
Total		330	100.0%	330	100.0%	330	100.0%	990	100.0%	
Religion	Jewish	330	100.0%			259	78.5%	589	59.5%	
	Muslim			144	43.6%	1	.3%	145	14.6%	
	Christian			103	31.2%	39	11.8%	142	14.3%	927.7***
	Druze			83	25.2%	1	.3%	84	8.5%	
	Other					30	9.1%	30	3.0%	
Total		330	100.0%	330	100.0%	330	100.0%	990	100.0%	
Escorted visit	Yes	219	66.4%	156	47.3%	214	65.0%	589	59.6%	
	No	111	33.6%	174	52.7%	115	35.0%	400	40.4%	30.15***
Total		330	100.0%	330	100.0%	329	100.0%	989	100.0%	

*** $p < .001$

Gender and marital status: Table 1 shows that the numbers of male and female patients in the three culture groups are identical, in accordance with the patient sample definition. A statistically significant difference was found among the three culture groups for marital status, with a higher percentage of widowed patients among Jewish-Israeli (JI) and FSU immigrant patients compared to Arab-Israeli (AI) patients, and a higher percentage of single and married patients among AI patients.

Religion: A statistically significant difference among the groups was found for religion, reflecting the initial choice of patients for the three culture groups.

Table 2: *Escorts according to patient culture*

		Patient culture			Total
		Jewish-Israeli N=110	Arab-Israeli N=163	FSU Immigrants N=117	
Relatives	n	96	151	102	349
	%	87.3	92.6	87.2	89.5
Others	n	14	12	15	41
	%	12.7	7.4	12.8	10.5
	χ^2		2.96 NS		

Escort to the visit: Table 2 reveals a statistically significant difference for the variable measuring whether patients arrived at the medical encounter accompanied by another person or alone. The lowest percentage of patients who arrived alone was found among AI patients, as was the highest percentage of patients accompanied by another person. These differences were statistically significant for the AI group compared with both the JI and the FSU immigrants groups. In all three groups the accompanying persons were mainly family members. An examination of patient escorts according to gender for each group indicated that for AI patients a higher proportion of the escorts were for females as compared to males (64% vs. 41%, $\chi^2 = 16.63$, $p < .001$). Similar results were found for male and female escorts for JI and FSU immigrant patients (around 30% and higher).

Table 3: *Means, SD's and medians of patients' ages according to patients' cultures*

Patient Gender		Patient culture			
		Jewish-Israeli	Arab-Israeli	FSU immigrants	Total
Male	M	47.43	41.02	53.93	47.46
	SD	18.75	14.08	17.76	17.75
	Mdn	50	38	55	47
Female	M	55.32	41.81	57.27	51.46
	SD	16.38	13.32	15.36	16.54
	Mdn	55	39	57	51
Total	M	51.37	41.41	55.60	49.46
	SD	18.02	13.69	16.66	17.27
	Mdn	53	38	56	49

Patient age: A 2-way Analysis of Variance (ANOVA) revealed significant differences among the ages of the patients in the three culture groups ($F_{(2,984)} = 67.91$, $p < .001$). Post hoc analyses (Tukey) showed that JI patients were significantly older than AI patients, and significantly younger than FSU immigrant patients (see Table 3), and the differences between the three groups varied according to gender. A statistically significant difference was found between the mean age of male and female patients, with the mean age of female patients ($F_{(1,984)} = 15.37$, $p < .001$) higher than the mean age of male patients. For female patients, the mean age of JI and FSU immigrant females was significantly higher than the mean age of AI patients. No statistically significant difference was found between the mean ages of JI patients and FSU immigrant patients. The gender differences between the three culture groups were found statistically significant in the interaction of gender x culture ($F_{(2,984)} = 4.14$, $p < .02$). For all groups, females were found to be older than males (55.32 vs. 47.43 for JI group, 41.81vs. 41.02 for AI group, and 57.27 vs. 53.27 for FSU immigrant group). The differences found in the study are congruent with the differing age structures of the three culture groups. According to Israel Central Bureau of Statistics data for 2003, the median age of JI citizens was 30.3 (31.7 for females). The median age of AI citizens was 19.7 (19.9 for females), and the median age of FSU immigrants was 36.6 (39.3 for females). In accordance with these statistics, the study's findings revealed the median age of JI patients to be less than that of FSU immigrant patients, and greater than that of AI patients.

Table 4: *Means and SD's of patient education according to patient culture*

	Patient culture		
	Jewish-Israeli	Arab-Israeli	FSU immigrants
Mean	12.61	9.97	14.35
SD	2.71	4.38	3.39

Patient education: As shown in Table 4, statistically significant differences were found for patient education (years of study) among the three culture groups ($F_{(2,979)} = 128.44$, $p < .001$). Tukey post hoc comparisons indicated that AI patients were significantly less educated (fewer years of study) than were JI and FSU immigrant patients, and JI patients were less educated than FSU immigrant patients.

Table 5: *Means and SD's of patients' self reported Hebrew proficiency according to patient culture and physician culture*

Patient culture		Physician culture			
		Jewish-Israeli	Arab-Israeli	FSU immigrants	Total
Jewish-Israeli	Mean	4.88	4.84	4.95	4.89
	SD	.38	.46	.21	.37
Arab-Israeli	Mean	3.54	3.67	3.98	3.73
	SD	1.31	1.23	1.14	1.24
FSU immigrants	Mean	2.60	2.46	2.52	2.53
	SD	1.19	1.10	1.05	1.11
Total	Mean	3.67	3.66	3.82	3.72
	SD	1.40	1.38	1.35	1.38

Hebrew proficiency: Statistically significant differences in self-reported Hebrew proficiency among patients from the three culture groups ($F_{(2,981)}$ =480.00, $p < .001$) were found for all the groups. FSU immigrant patients reported lower Hebrew proficiency than did JI and AI patients, while AI patients reported lower Hebrew proficiency than did JI patients. These differences were found to be statistically significant in patients visiting physicians from each of the three culture groups.

Table 6: *Frequency of translation assistance according to patient culture and patient gender*

Translation Received		Patient culture					
		Arab Israeli			FSU Immigrants		
		Gender		Total	Gender		Total
		Male	Female		Male	Female	
Yes	N	10	28	38	48	56	104
	%	6.1%	17.0%	11.5%	29.3%	33.7%	31.5%
No	N	155	137	292	116	110	226
	%	93.9%	83.0%	88.5%	70.7%	66.3%	68.5%
χ^2			9.64**			.76	
				39.08***			

*** $p<.001$ ** $p<.01$

Table 7: *Frequency of translator's identity according to patient culture and gender*

Translator's Identity		Patient culture					
		Arab-Israeli			FSU immigrants		
		Gender		Total	Gender		Total
		Male	Female		Male	Female	
Relatives	n	7	25	32	26	34	60
	%	77.8%	89.3%	86.5%	56.5%	59.6%	58.3%
Medical Staff	n	2	3	5	20	23	43
	%	22.2%	10.7%	13.5%	43.5%	40.4%	41.7%
χ^2			.77			.10	
				9.63**			

***p .01*

Language barriers: Table 6 shows that a higher percentage of FSU immigrant patients needed and used the assistance of translators (31%), compared to AI patients (11%). The difference in the frequency percentages was statistically significant *(χ^2= 39.08, p < .001)*. A statistically significant difference was found among AI patients between male and female patients who needed interpreting assistance, with a higher percentage of female patients requiring translation assistance (17.0% vs. 6.1%). No statistically significant difference was found among FSU immigrant patients with regard to patient gender; a similar percentage of male and female patients needed and received translation.

Table 7 shows that the main translators for AI patients were family members (86.5%), while for FSU immigrant patients, a lower percentage of family members translated (58.3%) and a higher percentage used the assistance of medical staff members (41.7%). These differences were statistically significant (χ^2= 9.63, p < .01).

All the variables in which statistical significant differences were found served as control variables during data analysis.

5.2 Hypotheses

The three hypotheses of the current study are as follows: (1) Patients from the three culture groups will exhibit differences in attitudes, needs, expectations, and satisfaction regarding the examined aspects of the medical encounter. (2) Patients from the three culture groups will exhibit differences in attitudes, needs, expectations, and satisfaction with respect to the

interaction between patient and physician culture. (3) Patients in culture-congruent groups will report that their needs, expectations and satisfaction were met to a higher degree than will patients in culture-incongruent groups.

The relevant findings regarding the three hypotheses are presented in Sections 5.2.1 through 5.2.4. Statistical tests were used to evaluate the results. Section 5.3 presents the results of the multiple regressions summarizing the study's findings. Section 5.4 offers additional data not directly correlated to the study's hypotheses, yet found to add extra value to the discussion.

5.2.1 Examining the Hypotheses

In order to reduce the number of statistical comparisons, hypotheses one and two were tested together using a two-way Multivariate Analysis of Variance (MANOVA), which tested three effects: patient culture, physician culture, and the interaction between patient and physician cultures. The results for each hypothesis are presented separately. A table summarizing means and SD's according to culture groups is given in Appendix G, and the results of the differences between the groups (P values and F values) are shown in Appendix H.

5.2.2 Analysis of Hypothesis No.1

The dependent variables for the first hypothesis were patient attitudes, needs, expectations, and satisfaction with the medical encounter, and the independent variable was patient culture. Since the three culture groups of patients were found statistically different for patient mean age, an additional analysis of covariance (ANCOVA) was conducted, with patient age and patient level of education as covariates. The independent variables were patient culture, and the dependent variables were patient attitudes, needs, expectations, and satisfaction with the medical encounter. The statistically significant differences between the three culture groups remained when controlling for patient age and patient level of education ($MF_{(24,1930)}=20.55$, $p<.001$). The results are summarized in Table 8 and illustrated in Figures 1 and 2.

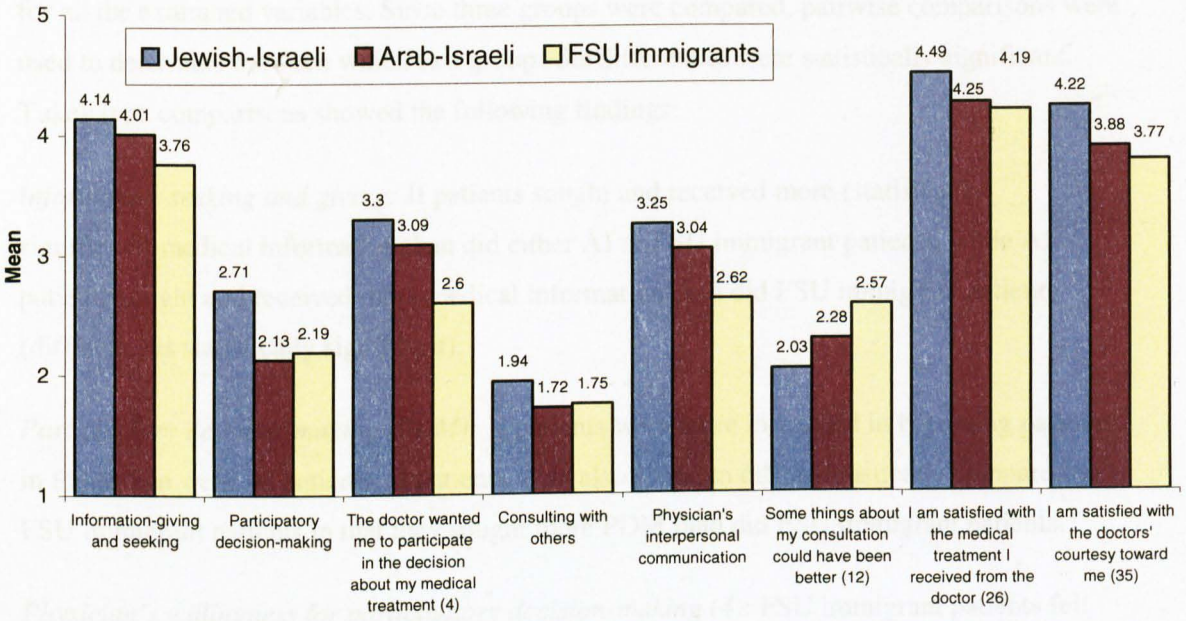
Table 8: *Comparisons of patient attitudes, needs, and satisfaction among the three culture groups: Means, SD's and F values*

		Patient culture			
		Jewish-Israeli	Arab-Israeli	FSU immigrants	F df = 2,987
Information-giving and seeking	M	4.14	4.01	3.76	25.21***
	SD	.61	.72	.77	
Participatory decision-making	M	2.71	2.13	2.19	16.69***
	SD	1.43	1.42	1.44	
The doctor wanted me to share with him/her the decision about my treatment (4)	M	3.30	3.09	2.60	20.22***
	SD	1.36	1.46	1.54	
Consulting with others	M	1.94	1.72	1.75	7.45***
	SD	.82	.78	.74	
Physician's interpersonal communication	M	3.25	3.04	2.62	47.77***
	SD	.85	.83	.89	
Some things about my consultation could have been better (12)	M	2.03	2.28	2.57	17.42***
	SD	1.12	1.16	1.23	
I am satisfied with the medical treatment I received from the doctor (26)	M	4.49	4.25	4.19	9.17***
	SD	.76	.98	1.08	
I am satisfied with the doctor's courtesy toward me (35)	M	4.22	3.88	3.77	20.03***
	SD	.90	.96	1.01	
Verbal communication	M	1.32	1.61	1.98	54.00***
	SD	.57	.84	1.01	
I prefer to be examined by a doctor who speaks my language (6)	M	3.42	2.56	4.15	74.55***
	SD	1.79	1.78	1.42	
Time	M	1.88	2.04	2.19	6.14**
	SD	1.06	1.13	1.21	
I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition (32)	M	1.80	2.68	2.02	43.03***
	SD	1.17	1.26	1.37	

** $p < .01$; ***$p < .001$

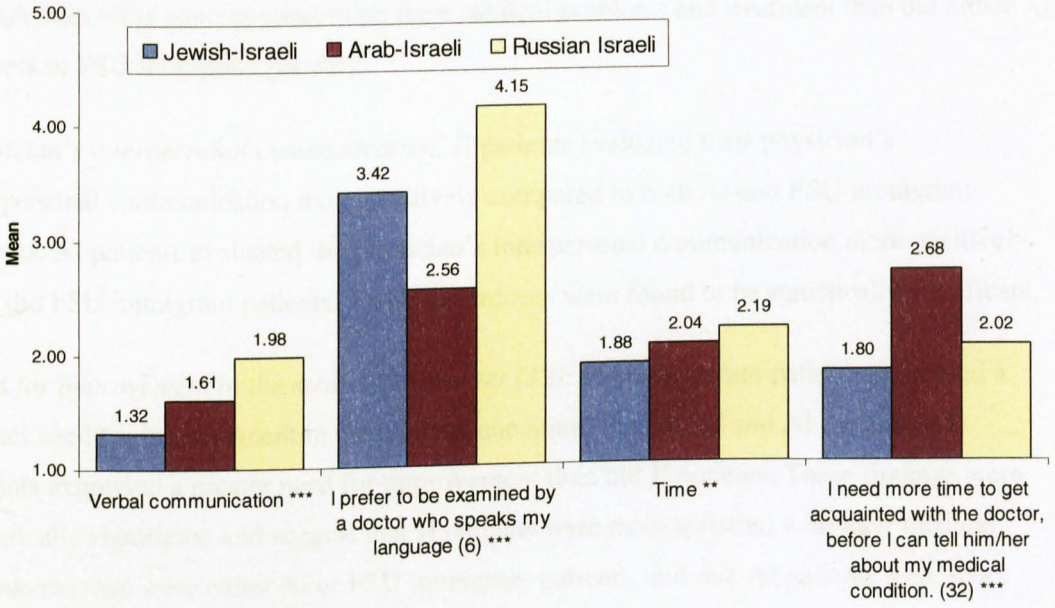
Wilks $\Delta = .61$, $MF_{(24,1952)} = 22.73$, $p<.001$

Figure 1: *Means of attitudes, needs and satisfaction of patients from the three culture groups, with respect to: information, decision-making, physician's interpersonal communication and overall satisfaction*



All differences are significant ($p < .001$)

Figure 2: *Means of attitudes, needs and satisfaction of patients from the three culture groups, with respect to: verbal communication and time*



** $p < .01$; ***$p < .001$

5.2.3 Results for Hypothesis No. 1

Statistically significant differences were found between the patients from the three cultures for all the examined variables. Since three groups were compared, pairwise comparisons were used to determine between which two groups the differences were statistically significant. Tukey type comparisons showed the following findings:

Information-seeking and giving: JI patients sought and received more (statistically significant) medical information than did either AI or FSU immigrant patients, while AI patients sought and received more medical information than did FSU immigrant patients (difference is statistically significant).

Participatory decision-making (PDM): JI patients were more interested in becoming partners in PDM than were AI patients. JI patients were also found to differ statistically compared to FSU immigrant patients in that they sought more PDM than did FSU immigrant patients.

Physician's willingness for participatory decision-making (4): FSU immigrant patients felt that their physicians were less willing to engage in PDM compared to the evaluations of JI and AI patients (statistically significant).

Consulting with others: JI patients expressed a greater desire (statistically significant) to consult with other sources concerning their medical problems and treatment than did either AI patients or FSU immigrant patients.

Physician's interpersonal communication: JI patients evaluated their physician's interpersonal communication more positively compared to both AI and FSU immigrant patients. AI patients evaluated the physician's interpersonal communication more positively than did FSU immigrant patients. These differences were found to be statistically significant.

Need for improvement in the medical encounter (12): FSU immigrant patients expressed a greater need for improvement in the medical encounter than did JI and AI patients. AI patients expressed a greater need for improvement than did JI patients. These findings were statistically significant and suggest that JI patients were more satisfied with their medical encounters than were either AI or FSU immigrant patients, and that AI patients were more satisfied with the visit than were FSU immigrant patients.

Patient satisfaction with medical treatment (26): JI patients were found to be more satisfied (statistically significant) with their physician's medical treatment compared to FSU

immigrant patients. No statistically significant differences were found between AI and FSU immigrant patients on this item.

Patient satisfaction with physician's courtesy (35): JI patients were found to be more satisfied (statistically significant) with their physician's courtesy compared to both AI and FSU immigrant patients. No statistically significant differences were found between AI and FSU immigrant patients for this item.

Verbal communication: The findings show that FSU immigrant patients suffered from more language difficulties in comparison with both AI and JI patients. AI patients suffered from more problems deriving from language barriers than did JI patients. A statistically significant difference was found between each two groups in the three culture groups.

Since interpretation services were applicable for AI and FSU patients, the effect of culture and interpretation on verbal communication problems was tested, using 2-way ANOVA. The two independent variables were culture and interpreter-use during the encounter, while the dependent variable was verbal communication.

The ANOVA revealed that patients who needed and received translation reported more communication problems (mean 2.66, SD 0.77) compared to those who did not receive translation assistance (mean 1.56, SD 0.84), ($F_{(1.656)} = 166.04$, $p < .001$). This difference was not found to depend on patient culture, i.e., AI and FSU immigrant patients suffered equally from language barriers.

Preference of physician's spoken language (6): FSU immigrant patients expressed a greater preference to be examined by physicians speaking their own language than did either JI or AI patients. JI patients expressed greater preference to be seen by physicians speaking their own language than did AI patients. These differences were found to be statistically significant.

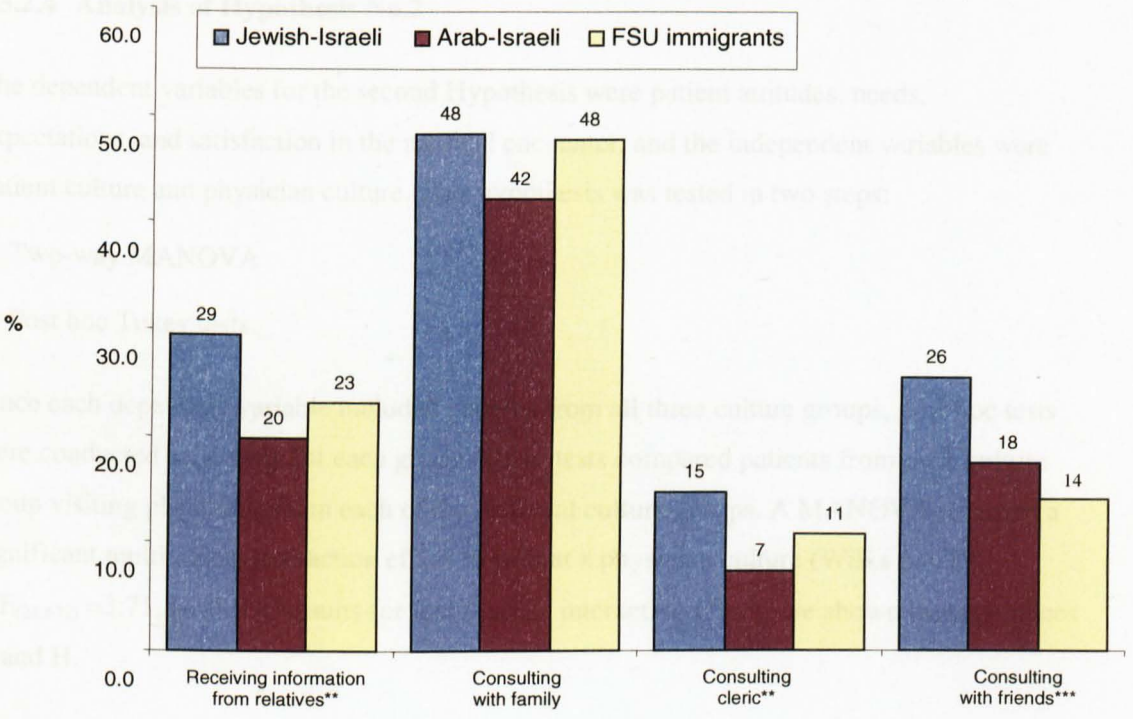
Time: The only statistically significant difference concerning lack of time during the medical encounter was found between JI patients and FSU immigrant patients. FSU immigrant patients suffered from lack of time more than did JI patients.

Need for more time to get acquainted with the doctor (32): AI patients expressed a greater need for time to get acquainted with the physician compared to both JI and FSU immigrant patients (statistically significant).

Patient consultants: To explore the identity of patient consultants, each one of the statements comprising the sub-scale "consulting with others" was analyzed separately. The Likert scale for each statement was recoded to two categories: patients who answered "totally disagree"

(1) or "agree mildly" (2) were recoded as "low", while patients who answered "agree moderately" (3), "agree very much" (4) or "agree totally" (5) were recoded as "high". All four statements were analyzed using Chi square tests, and their answer distributions (in percentages) are shown in Figure 3.

Figure 3: *Percentages of patients expressing desire to consult with relatives, friends and religious clerics, according to culture group*



p<.01;*p < .001

Figure 3 demonstrates the significant differences between the three culture groups of patients regarding their desire to receive additional information from relatives (χ^2=8.77, p < .01), to consult with religious clerics (χ^2=9.67, p < .01) and to consult with friends (χ^2=14.16, p < .001). Additional Chi square tests between culture group pairs indicated that the source of difference between the three culture groups was between JI patients and AI patients with respect to three measures: (1) JI patients were found to express greater desire to receive additional information from relatives (29%) as compared to AI patients (20%), (χ^2=8.38, p < .01); (2) JI patients were found to express more desire to consult with a rabbi (15%) as compared to AI patients' desire to consult with a sheikh or priest (7%), (χ^2=9.63, p < .01);

and (3) JI patients were found to express more desire to consult with friends (26%) than were AI patients (18), (χ^2=6.07, $p < .01$).

A higher percent of JI patients expressed a desire to consult with friends (26%), compared to FSU immigrant patients (14%). This difference was found to be statistically significant (χ^2=13.04, $p < .001$). The percentage of patients who expressed a desire to consult with family members was similar in all three culture groups. No significant differences were found between AI and FSU immigrant patients regarding all four statements.

5.2.4 Analysis of Hypothesis No.2

The dependent variables for the second Hypothesis were patient attitudes, needs, expectations, and satisfaction in the medical encounter, and the independent variables were patient culture and physician culture. This hypothesis was tested in two steps:

1) Two-way MANOVA

2) Post hoc Tukey tests.

Since each dependent variable included patients from all three culture groups, post hoc tests were conducted separately for each group. These tests compared patients from each culture group visiting physicians from each of the different culture groups. A MANOVA revealed a significant multivariate interaction effect of patient x physician culture (Wilks Δ =.77, $MF_{(24,632)}$ =3.71, $p<.001$). Results for multivariate interaction effects are shown in Appendices G and H.

5.2.4.1 Jewish-Israeli patients

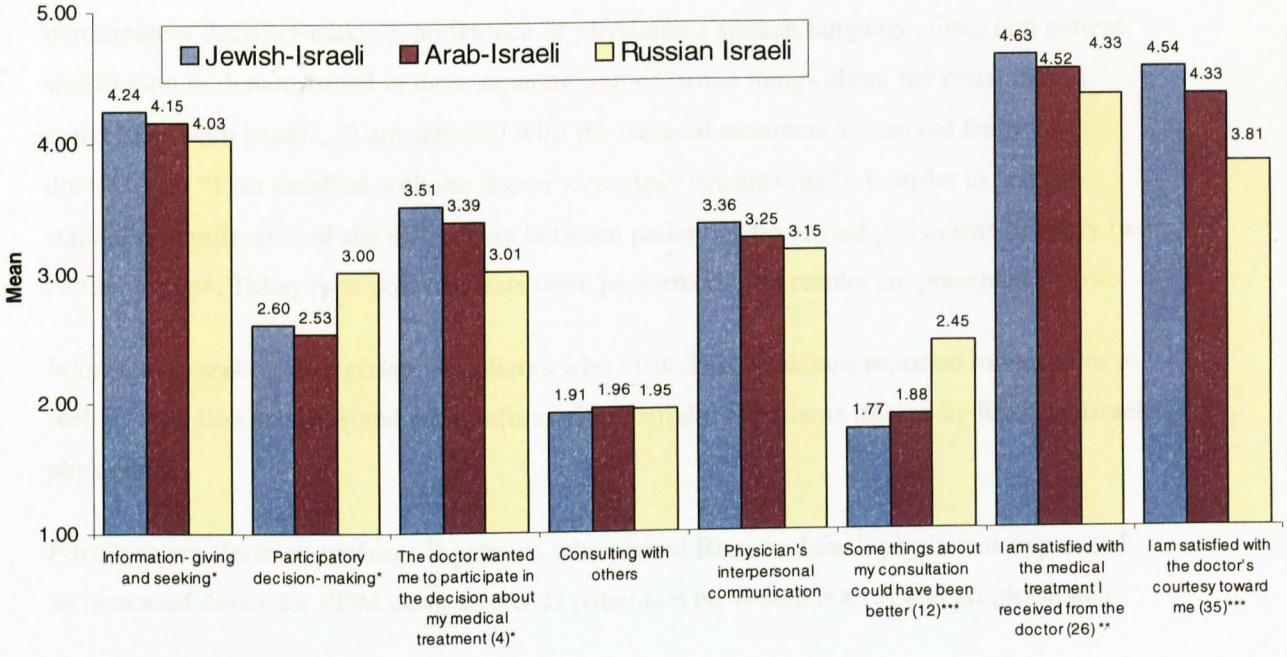
Table 9: *Comparisons between Jewish-Israeli patients who visited physicians from the three culture groups, with respect to attitudes, needs and satisfaction: Means, SD's and F values*

Physician culture:		A Jewish-Israeli	B Arab-Israeli	C Russian-Israeli	F df=2,327	Pairwise differences (Tukey test)
Information-seeking and giving	M	4.24	4.15	4.03	3.45*	A>C
	SD	.51	.57	.71		
Participatory decision-making	M	2.60	2.53	3.00	3.57*	B<C
	SD	1.39	1.47	1.43		
The doctor wanted me to share with him/her the decision about my treatment (4)	M	3.51	3.39	3.01	4.14*	A>C
	SD	1.28	1.33	1.43		
Consulting with others	M	1.91	1.96	1.95	0.09	
	SD	.83	.84	.80		
Physician's interpersonal communication	M	3.36	3.25	3.15	1.69	
	SD	.75	.79	.98		
Some things about my consultation could have been better (12)	M	1.77	1.88	2.45	12.28***	A,B<C
	SD	1.03	1.02	1.19		
I am satisfied with the medical treatment I received from the doctor (26)	M	4.63	4.52	4.33	4.47**	A>C
	SD	.57	.70	.94		
I am satisfied with the doctor's courtesy towards me (35)	M	4.54	4.33	3.81	21.32***	A,B>C
	SD	.74	.84	.96		
Verbal communication	M	1.23	1.36	1.36	1.79	
	SD	.42	.60	.67		
I prefer to be examined by a doctor who speaks my language (6)	M	3.43	2.91	3.92	9.16***	B<C
	SD	1.84	1.76	1.63		
Time	M	1.83	1.73	2.09	3.30*	B<C
	SD	1.04	.95	1.16		
I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition (32)	M	1.74	1.76	1.91	0.69	
	SD	1.20	1.12	1.19		

* $p < .05$; ** $p < .01$; *** $p < .001$

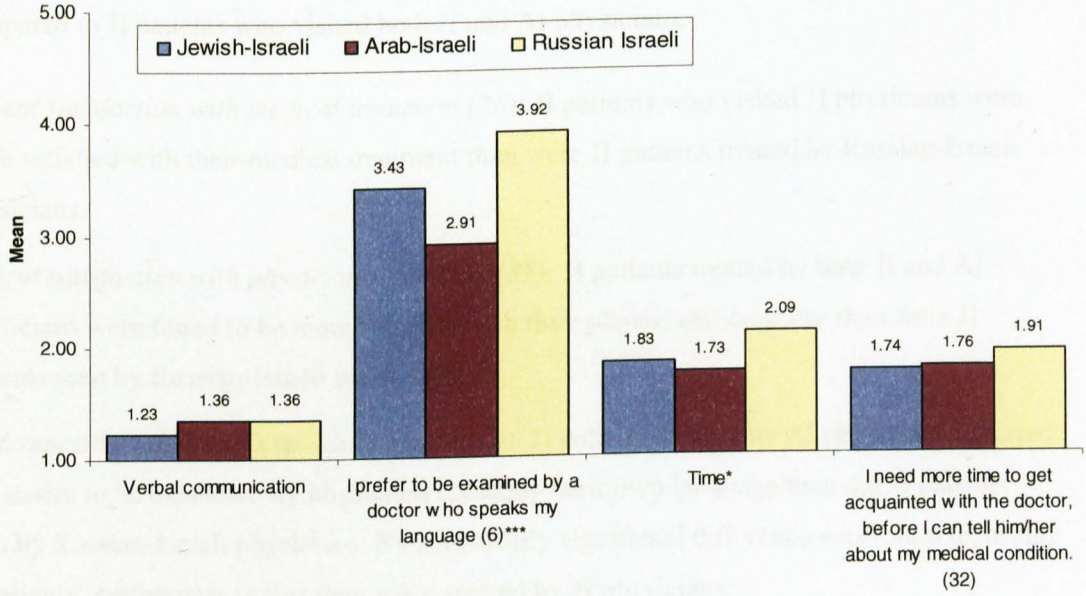
Wilks $\Delta = .77$, $MF_{(24.632)} = 3.71$, $p < .001$

Figure 4: *Comparisons of means between Jewish-Israeli patients who visited physicians from the three culture groups, with respect to: information, participatory decision-making, physician's interpersonal communication and overall satisfaction*



*$p < .05$; **$p < .01$; ***$p < .001$

Figure 5: *Comparisons of means between Jewish-Israeli patients who visited physicians from the three culture groups, with respect to: verbal communication and time*



*$p < .05$; ***$p < .001$

Results for Jewish-Israeli patients are shown in Table 9 and Figures 4 and 5. Table 9 shows that statistically significant differences were found between JI patients who visited physicians from the three culture groups on the following items: information-seeking and giving, participatory decision-making, preference of physician's spoken language, time, and patient satisfaction as demonstrated in three separate items ("some things about my consultation could have been better", "I am satisfied with the medical treatment I received from the doctor", and "I am satisfied with the doctor's courtesy towards me"). In order to test the statistical significance of the differences between patients who visited physicians of every two culture groups, Tukey type post hoc tests were performed. The results are presented below.

Information-seeking and giving: JI patients who visited JI physicians reported more desire to seek information and received more information than did JI patients treated by Russian-Israeli physicians.

Participatory decision-making: JI patients who visited Russian-Israeli physicians expressed an increased desire for PDM compared to JI patients who visited both JI and AI physicians.

Physician's willingness for participatory decision-making (4): JI patients treated by Russian-Israeli physicians reported that their physicians were less open to PDM compared to JI patients seen by JI physicians, who reported increased physician willingness.

Need for improvement in the medical encounter (12): JI patients treated by Russian-Israeli physicians were found to express more need for improvement in the medical encounter compared to JI patients who visited both JI and AI physicians.

Patient satisfaction with medical treatment (26): JI patients who visited JI physicians were more satisfied with their medical treatment than were JI patients treated by Russian-Israeli physicians.

Patient satisfaction with physician's courtesy (35): JI patients treated by both JI and AI physicians were found to be more satisfied with their physicians' courtesy than were JI patients seen by Russian-Israeli physicians.

Preference for physician's spoken language (6): JI patients treated by AI physicians reported less desire to be examined by physicians speaking their own language than did JI patients seen by Russian-Israeli physicians. No statistically significant difference was found regarding JI patients' preferences in this item when treated by JI physicians.

Time: JI patients who visited AI physicians reported to have suffered less from lack of time during the medical encounter compared to JI patients seen by Russian-Israeli physicians.

5.2.4.2 Arab-Israeli patients

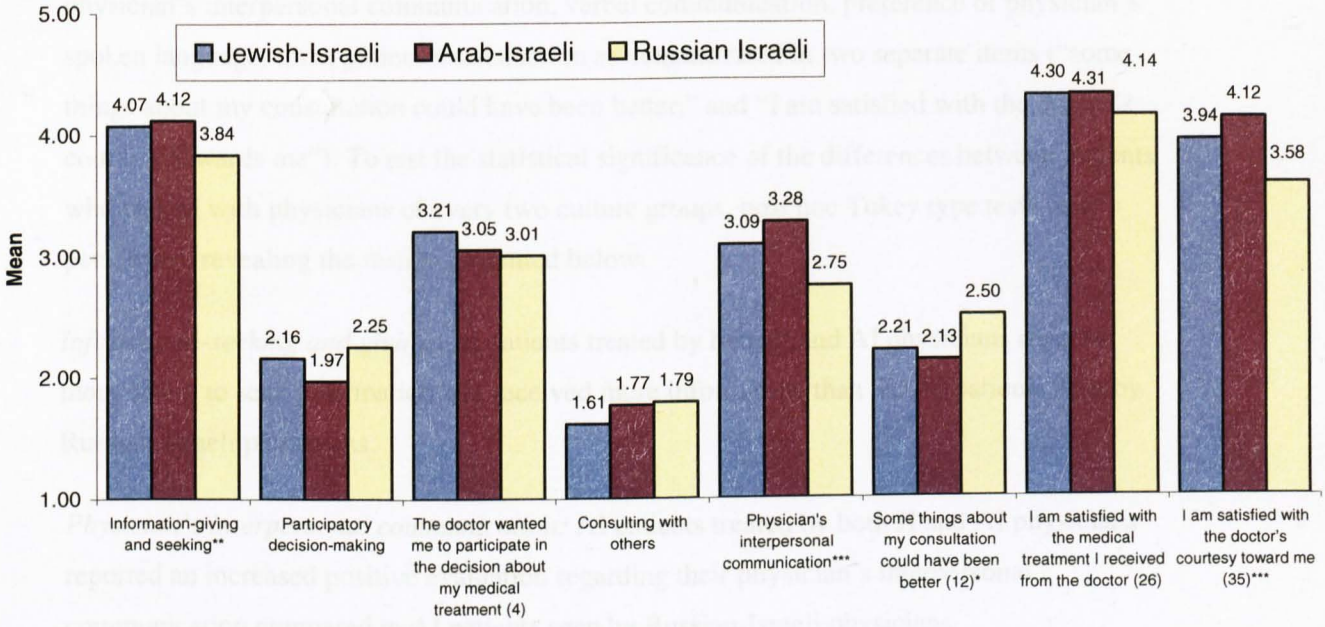
Table 10: *Comparisons between Arab-Israeli patients who visited physicians from the three culture groups, with respect to attitudes, needs and satisfaction: Means, SD's and F values*

Physician culture:		A Jewish-Israeli	B Arab-Israeli	C Russian-Israeli	F df=2, 327	Pairwise differences (Tukey test)
Information-seeking and giving	M	4.07	4.12	3.84	4.99**	A,B>C
	SD	0.66	0.58	0.87		
Participatory decision-making	M	2.16	1.97	2.25	1.16	
	SD	1.42	1.42	1.40		
The doctor wanted me to share with him/her the decision about my treatment (4)	M	3.21	3.05	3.01	0.56	
	SD	1.41	1.47	1.52		
Consulting with others	M	1.61	1.77	1.79	1.74	
	SD	0.60	0.83	0.87		
Physician's interpersonal communication	M	3.09	3.28	2.75	*** 12.33	A,B>C
	SD	0.74	0.82	0.84		
Some things about my consultation could have been better (12)	M	2.21	2.13	2.50	3.18*	B>C
	SD	1.15	1.15	1.16		
I am satisfied with the medical treatment I received from the doctor (26)	M	4.30	4.31	4.14	1.08	
	SD	0.92	0.92	1.09		
I am satisfied with the doctor's courtesy towards me (35)	M	3.94	4.12	3.58	*** 9.33	A,B>C
	SD	0.92	0.85	1.03		
Verbal communication	M	1.69	1.28	1.85	*** 14.58	A,C>B
	SD	0.85	0.60	0.92		
I prefer to be examined by a doctor who speaks my language (6)	M	2.42	2.94	2.33	3.79*	B>C
	SD	1.76	1.86	1.68		
Time	M	1.95	1.88	2.30	4.51**	A,B>C
	SD	1.08	1.05	1.21		
I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition (32)	M	2.59	2.83	2.64	1.09	
	SD	1.18	1.34	1.25		

* $p < .05$; ** $p < .01$; *** $p < .001$

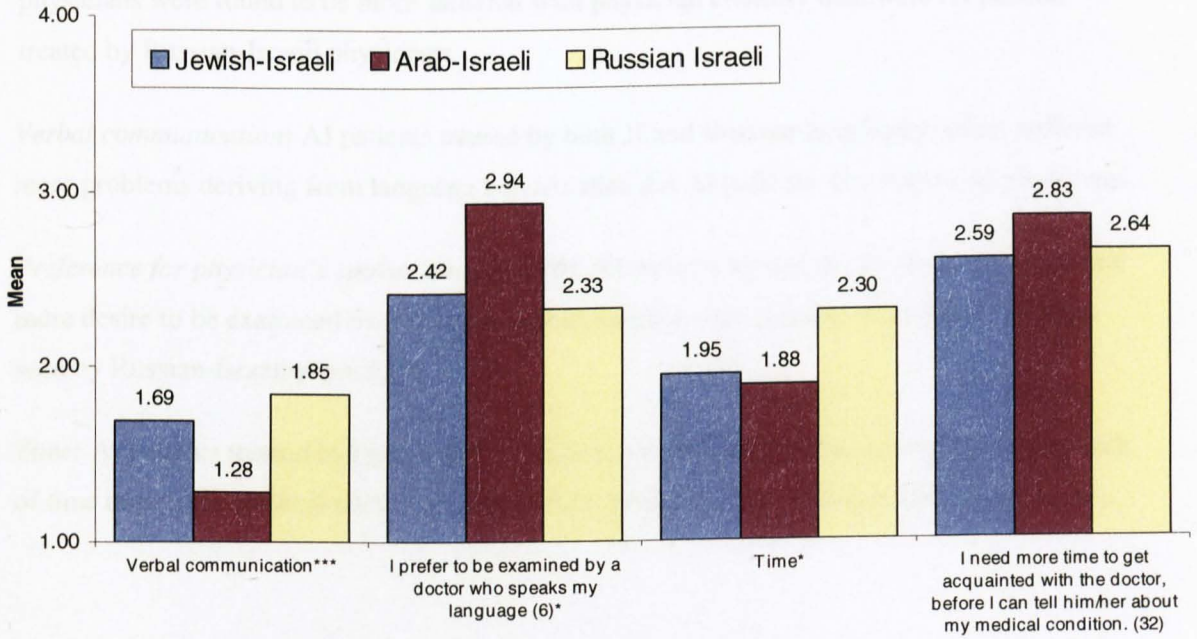
Wilks $\Delta = .75$, $MF_{(24,632)} = 3.99$, $p < .001$

Figure 6: *Comparisons of means between Arab-Israeli patients who visited physicians from the three culture groups, with respect to: information, participatory decision-making, physician's interpersonal communication and overall satisfaction*



* p < .05; ** p < .01; *** p < .001

Figure 7: *Comparisons of means between Arab-Israeli patients who visited physicians from the three culture groups, with respect to: verbal communication and time*



* p < .05; *** p < .001

Table 10 reveals statistically significant differences between AI patients who visited physicians of the three culture groups on the following items: information-seeking and giving, physician's interpersonal communication, verbal communication, preference of physician's spoken language, time, patient's satisfaction as demonstrated in two separate items ("some things about my consultation could have been better," and "I am satisfied with the doctor's courtesy towards me"). To test the statistical significance of the differences between patients who visited with physicians of every two culture groups, post hoc Tukey type tests were performed, revealing the results presented below.

Information-seeking and giving: AI patients treated by both JI and AI physicians reported more desire to seek information and received more information than did AI patients seen by Russian-Israeli physicians.

Physician's interpersonal communication: AI patients treated by both JI and AI physicians reported an increased positive evaluation regarding their physician's interpersonal communication compared to AI patients seen by Russian-Israeli physicians.

Need for improvement in the medical encounter (12): AI patients treated by Russian-Israeli physicians expressed more need for improvement in the medical encounter than did AI patients treated by AI physicians.

Patient satisfaction with physician's courtesy (35): AI patients treated by both AI and JI physicians were found to be more satisfied with physician courtesy than were AI patients treated by Russian-Israeli physicians.

Verbal communication: AI patients treated by both JI and Russian-Israeli physicians suffered more problems deriving from language barriers than did AI patients who visited AI physicians.

Preference for physician's spoken language (6): AI patients treated by AI physicians reported more desire to be examined by physicians speaking their own language than did AI patients seen by Russian-Israeli physicians.

Time: AI patients treated by both JI and AI physicians reported to have suffered less from lack of time during the medical encounter than did AI patients seen by Russian-Israeli physicians.

5.2.4.3 FSU immigrant patients

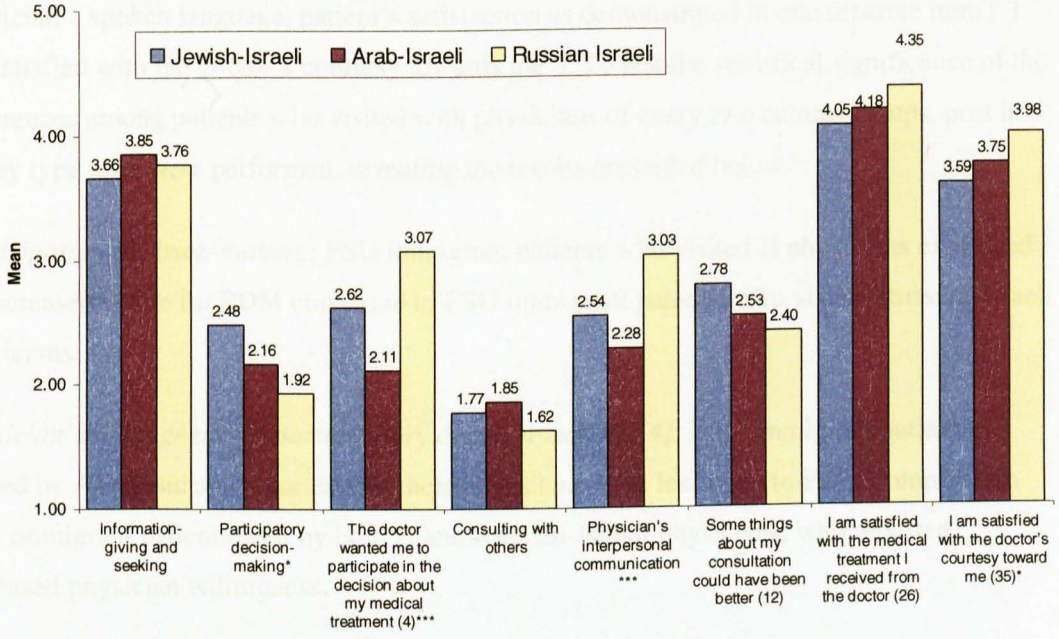
Table 11: *Comparison between FSU immigrant patients who visited physicians from the three culture groups, in the aspects of attitudes, needs and satisfaction: Means, SD's and F values*

Physician culture:		A Jewish-Israeli	B Arab-Israeli	C Russian-Israeli	F df=2,327	Pairwise differences (Tukey test)
Information-seeking and giving	M	3.66	3.85	3.76	1.83	
	SD	0.87	0.72	0.71		
Participatory decision-making	M	2.48	2.16	1.92	4.16*	A>C
	SD	1.59	1.39	1.26		
The doctor wanted me to share with him/her the decision about my treatment (4)	M	2.62	2.11	3.07	11.45***	A,C>B
	SD	1.58	1.33	1.56		
Consulting with others	M	1.77	1.85	1.62	2.70	
	SD	0.76	0.75	0.69		
Physician's interpersonal communication	M	2.54	2.28	3.03	23.47***	A,B<C A>B
	SD	0.90	0.72	0.86		
Some things about my consultation could have been better (12)	M	2.78	2.53	2.40	2.79	
	SD	1.31	1.22	1.13		
I am satisfied with the medical treatment I received from the doctor (26)	M	4.05	4.18	4.35	2.29	
	SD	1.20	1.08	0.92		
I am satisfied with the doctor's courtesy towards me (35)	M	3.59	3.75	3.98	4.26*	A<C
	SD	1.11	0.99	0.89		
Verbal communication	M	2.28	2.23	1.44	28.07***	A,B>C
	SD	1.10	0.91	0.76		
I prefer to be examined by a doctor who speaks my language (6)	M	3.81	3.87	4.77	17.34***	A,B<C
	SD	1.55	1.63	0.70		
Time	M	2.34	2.07	2.17	1.44	
	SD	1.29	1.15	1.19		
I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition (32)	M	2.15	2.02	1.91	0.82	
	SD	1.46	1.39	1.25		

* $p < .05$; ** $p < .01$; *** $p < .001$

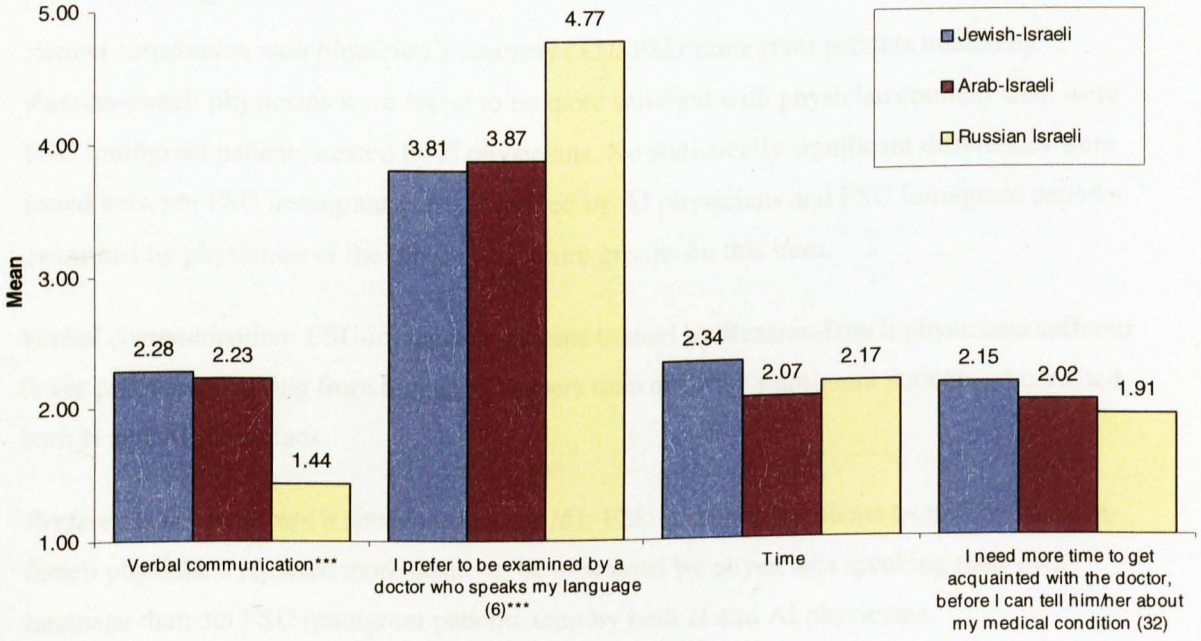
Wilks $\Delta = .52$, $MF_{(24,632)} = 10.12$, $p < .001$

Figure 8: *Comparisons of Means between FSU immigrant patients who visited physicians from the three culture groups, with respect to: Information, participatory decision-making, physician's interpersonal communication and overall satisfaction*



*$p < .05$; ***$p < .001$

Figure 9: *Comparisons of means between FSU immigrant patients who visited physicians from the three culture groups, with respect to verbal communication and time*



*** $p < .001$

Table 11 reveals statistically significant differences among FSU immigrant patients who visited physicians of the three culture groups on the following items: participatory decision-making, physician's interpersonal communication, verbal communication, preference of physician's spoken language, patient's satisfaction as demonstrated in one separate item ("I am satisfied with the doctor's courtesy towards me"). To test the statistical significance of the differences among patients who visited with physicians of every two culture groups, post hoc Tukey type tests were performed, revealing the results presented below.

Participatory decision-making: FSU immigrant patients who visited JI physicians expressed an increased desire for PDM compared to FSU immigrant patients who visited Russian-Israeli physicians.

Physician's willingness for participatory decision-making (4): FSU immigrant patients treated by AI physicians reported that their physicians were less open to PDM compared to FSU immigrant patients seen by both JI and Russian-Israeli physicians, who reported increased physician willingness.

Physician's interpersonal communication: FSU immigrant patients treated by Russian-Israeli physicians reported an increased positive evaluation regarding their physician's interpersonal communication compared to FSU immigrant patients seen by both JI and AI physicians. FSU immigrant patients treated by AI patients reported a more negative evaluation of physician's interpersonal communication than did FSU immigrant patients seen by JI physicians.

Patient satisfaction with physician's courtesy (35): FSU immigrant patients treated by Russian-Israeli physicians were found to be more satisfied with physician courtesy than were FSU immigrant patients treated by JI physicians. No statistically significant differences were found between FSU immigrant patients treated by AI physicians and FSU immigrant patients examined by physicians of the other two culture groups on this item.

Verbal communication: FSU immigrant patients treated by Russian-Israeli physicians suffered fewer problems deriving from language barriers than did FSU immigrant patients who visited both JI and AI physicians.

Preference for physician's spoken language (6): FSU immigrant patients treated by Russian-Israeli physicians reported more desire to be examined by physicians speaking their own language than did FSU immigrant patients seen by both JI and AI physicians.

5.2.5 Results for Hypothesis No. 2

The findings of the study suggest that patient culture and physician culture indeed interacted regarding patient attitudes, needs and satisfaction.

Information-seeking and giving: JI patients were found to seek and receive more information from physicians from their own culture group only. AI patients reported seeking and receiving more information when treated by JI and AI physicians than when visiting Russian-Israeli physicians. FSU immigrant patients did not report differential information-seeking and giving behaviours when visiting physicians from the three culture groups.

Participatory decision-making: JI patients expressed an increased desire for PDM only when visiting Russian-Israeli physicians. AI patients did not report differential behaviour regarding desire for PDM. FSU immigrant patients who visited JI physicians expressed an increased desire for PDM compared to when visiting Russian-Israeli physicians.

Physician's interpersonal communication: JI patients did not report differential evaluations for physicians from the three culture groups with respect to physician interpersonal communication. AI patients, in contrast, reported different levels of evaluations: when treated by either JI or AI physicians, they reported an increased positive evaluation of physician's interpersonal communication style as compared to visits to Russian-Israeli physicians. FSU immigrant patients also reported different levels of evaluation, evaluating physicians from their own culture group more positively than either JI or AI physicians. FSU immigrant patients treated by AI physicians were less positive regarding this item than those seen by JI physicians.

Need for improvement in the medical encounter (12): JI patients were found to express a need for improvement in the medical encounter only when treated by Russian-Israeli physicians. AI patients treated by Russian-Israeli physicians expressed more need for improvement than did AI patients treated by culture-congruent physicians. FSU immigrant patients did not report differences on this item.

Patient satisfaction with medical treatment (26): JI patients who visited culture-congruent physicians were more satisfied with their medical treatment than were JI patients treated by Russian-Israeli physicians. No differences were found regarding satisfaction with medical treatment for either AI patients or FSU immigrant patients.

Patient satisfaction with physician courtesy (35): JI patients treated by JI and by AI physicians were found to be more satisfied with physician courtesy than were JI patients seen

by Russian-Israeli physicians. Similarly, AI patients treated by AI and by JI physicians were found to be more satisfied with physician courtesy than were AI patients treated by Russian-Israeli physicians. FSU immigrant patients treated by culture-congruent physicians were found to be more satisfied with physician courtesy than were FSU immigrant patients seen by JI physicians.

Verbal communication: JI patients did not suffer from problems deriving from language barriers. AI patients suffered from language barriers only when treated by Russian-Israeli physicians. FSU immigrant patients reported differences for this problem: patients of culture-congruent physicians suffered fewer problems than their counterparts who visited JI and AI physicians.

Preference for physician's spoken language (6): JI patients treated by AI physicians reported less desire to be examined by physicians speaking their own language than did JI patients seen by Russian-Israeli physicians. AI patients treated by culture-congruent physicians reported more desire to be examined by physicians speaking their own language than did AI patients seen by Russian-Israeli physicians. FSU immigrant patients treated by culture-congruent physicians reported more desire to be examined by physicians speaking their own language than did FSU immigrant patients seen by both JI and AI physicians.

Time: JI patients who visited AI physicians reported suffering less from lack of time during the medical encounter than did JI patients seen by Russian-Israeli physicians. AI patients reported differences between their visits with physicians from the three culture groups: AI patients treated by both JI and AI physicians reported to have suffered less from lack of time than did AI patients seen by Russian-Israeli physicians. FSU immigrant patients did not report differences regarding time when visiting physicians from any of the three culture groups.

5.2.6 Analysis of Hypothesis No.3

To find the differences between patients in culture-congruent groups and those in culture-incongruent groups, all participating patients were divided into two groups:

1) Patients seen by culture-congruent physicians (330 patients).

2) Patients seen by culture-incongruent physicians (660 patients).

For comparing between these two groups, a 2-way MANOVA was performed, with patient attitudes, needs, expectations, and satisfaction expressed in the questionnaire as dependent variables, and congruence between physician culture and patient culture (culture congruence/in-congruence) and patient gender as independent variables.

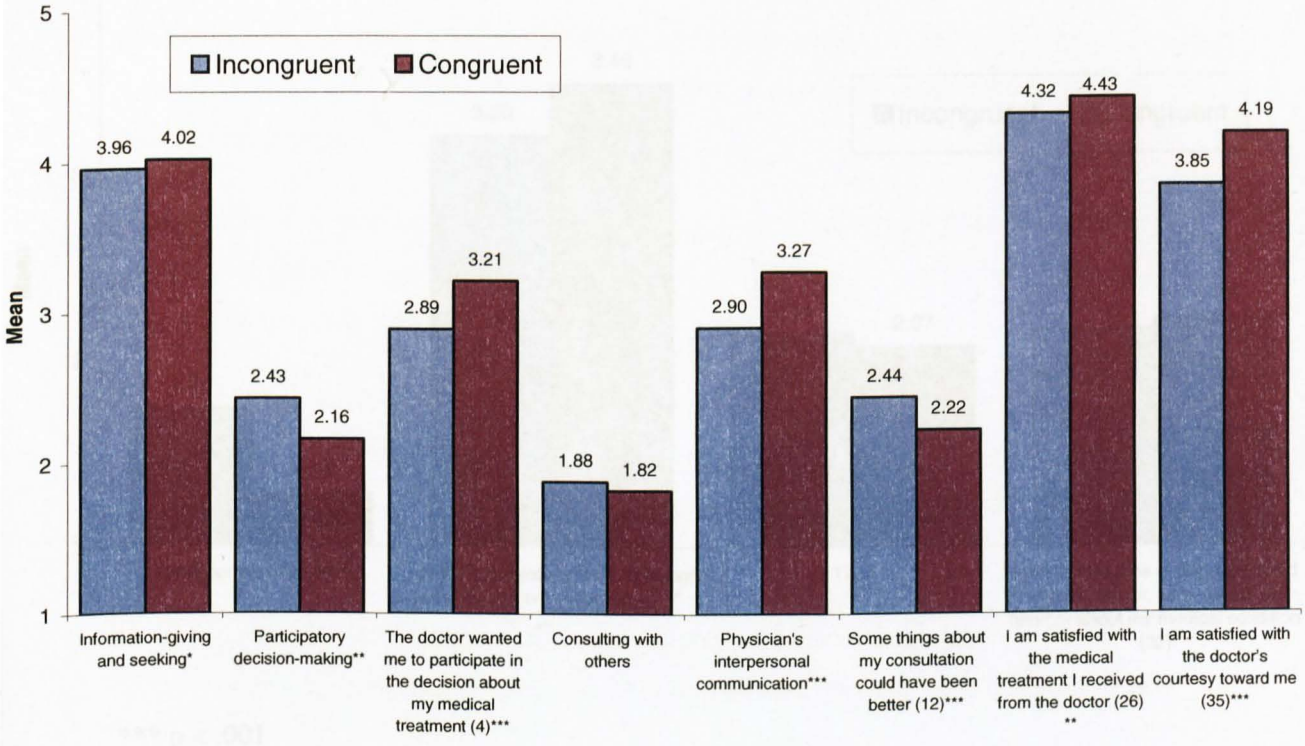
Table 12: *Comparisons between culture-congruent and culture-incongruent physician-patient dyads regarding attitudes, needs and satisfaction: Means, SD's and F values*

Patient and physician culture		Incongruent N=660	Congruent N=330	F df = 1,986
Information-seeking and giving	M	3.96	4.02	4.72*
	SD	.76	.66	
Participatory decision-making	M	2.43	2.16	7.38**
	SD	1.47	1.39	
The doctor wanted me to share with him/her the decision about my treatment (4)	M	2.89	3.21	10.40***
	SD	1.49	1.45	
Consulting with others	M	1.88	1.82	1.01
	SD	.81	.78	
Physician's interpersonal communication	M	2.90	3.27	41.47***
	SD	.90	.83	
Some things about my consultation could have been better (12)	M	2.44	2.22	13.39***
	SD	1.21	1.16	
I am satisfied with the medical treatment I received from the doctor (26)	M	4.32	4.43	7.75**
	SD	1.00	.85	
I am satisfied with the doctor's attitude courtesy towards me (35)	M	3.85	4.19	34.43***
	SD	1.02	.86	
Verbal communication	M	1.74	1.28	71.21***
	SD	.91	.59	
I prefer to be examined by a doctor who speaks my language (6)	M	3.20	3.48	17.62***
	SD	1.77	1.81	
Time	M	2.14	2.07	2.39
	SD	1.17	1.15	
I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition (32)	M	2.16	2.22	.05
	SD	1.26	1.36	

* $p < .05$; ** $p < .01$; *** $p < .001$

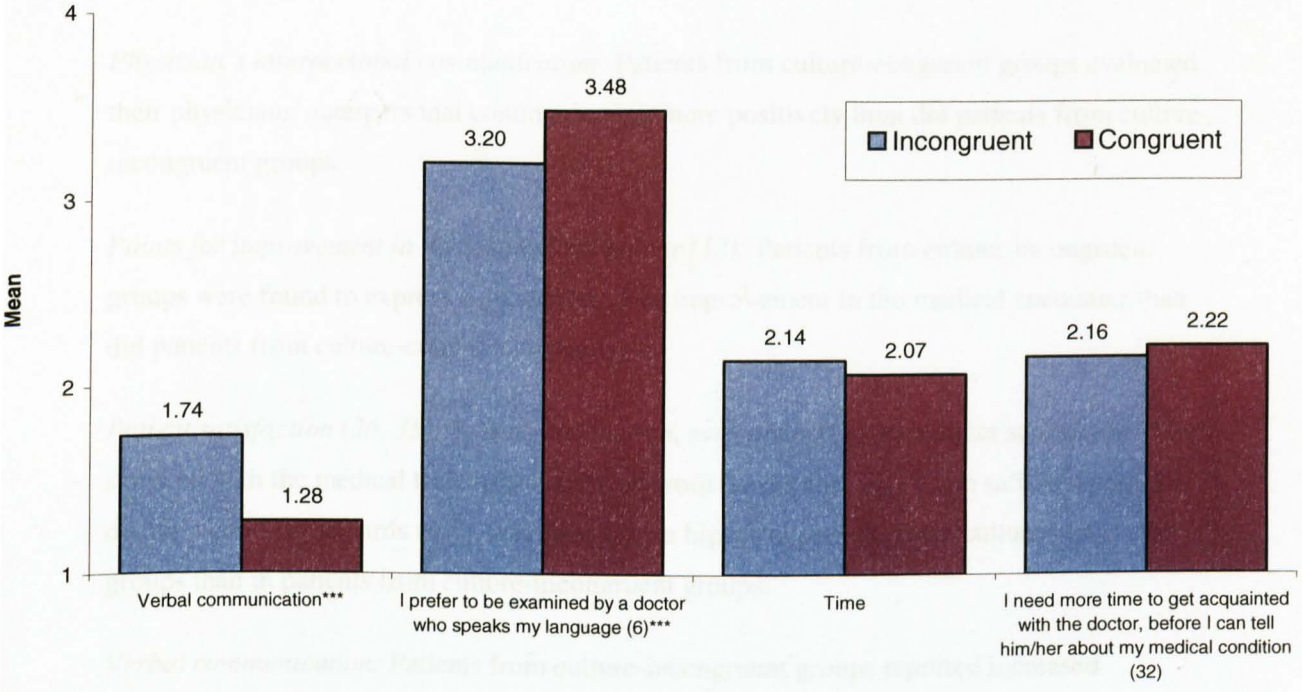
WilksΔ=.85, $MF_{(11,978)} = 16.95$, $p < .001$

Figure 10: *Comparisons of means between culture-congruent and culture-incongruent physician-patient dyads, with respect to: information, decision-making, physician's interpersonal communication, and overall satisfaction*



* $p < .05$; ** $p < .01$; *** $p < .001$

Figure 11: *Comparisons of means between culture-congruent and culture-incongruent physician-patient dyads, with respect to: verbal communication and time*



*** $p < .001$

5.2.7 Results of Hypothesis No. 3

Table 12 shows that statistically significant differences were found between culture-congruent and incongruent physician-patient dyads on the following: information-giving and seeking, participatory decision-making, physician's interpersonal communication, verbal communication, preference of physician's spoken language, patient satisfaction as demonstrated by three separate statements ("Some things about my consultation could have been better", "I am satisfied with the medical treatment I received from the doctor" and "I am satisfied with the doctor's courtesy towards me"). These results are illustrated in Figures 10 and 11, and summarized below.

Information-seeking and giving: Patients from culture-incongruent groups reported fewer information-seeking needs and less information given by their physicians than did patients from culture-congruent groups.

Participatory decision-making: Patients' desire for PDM with their physicians was reported higher in patients from culture-incongruent groups.

Physician's willingness for participatory decision-making (4): Patients in culture-congruent dyads reported that physicians were more open to PDM compared to patients from culture-incongruent dyads.

Physician's interpersonal communication: Patients from culture-congruent groups evaluated their physicians' interpersonal communication more positively than did patients from culture-incongruent groups.

Points for improvement in the medical encounter (12): Patients from culture-incongruent groups were found to express a greater need for improvement in the medical encounter than did patients from culture-congruent groups.

Patient satisfaction (26, 35): Patient satisfaction, as examined by two direct statements ("I am satisfied with the medical treatment I received from the doctor" and "I am satisfied with the doctor's courtesy towards me"), was found to be higher in patients from culture-congruent groups than in patients from culture-incongruent groups.

Verbal communication: Patients from culture-incongruent groups reported increased problems deriving from language barriers than did patients from culture-congruent groups.

Preference of physician's language (6): Patients from culture-congruent groups were found to prefer being treated by physicians speaking their language, compared to patients from culture-incongruent groups.

No statistically significant differences were found between patients from culture-congruent groups and patients from culture-incongruent groups regarding time, consulting with others, and time to get acquainted with the physician.

None of the differences between patients from culture-congruent groups and culture-incongruent groups were found to be gender dependent, i.e., all the reported differences were found among male as well as female patients. The interaction effect of gender x culture congruence was found insignificant: ($MF_{(10,647)} = .59$, P=NS).

Table 13: *Multiple regression analyses for information, decision-making, physician's interpersonal communication, overall satisfaction: Beta coefficients* R^2 *and P values*

	Information-seeking and giving	Participatory decision-making	The doctor wanted me to participate...(4)	Consulting with others	Physician's interpersonal communication	Needs for improvement in the medical encounter (12)	Patient satisfaction with medical treatment (26)	Patient satisfaction with physician's courtesy (35)
Patient and physician culture	0.070*	-0.08**	0.11***	-0.03	0.21***	-0.11***	0.09**	0.18***
Gender (1=Male)	0.02	0.01	0.01	0.06	0.05	0.04	0.05	0.02
Marital Status (1=Married)	-0.03	0.01	0.02	0.05	-0.01	0.02	0.01	-0.03
Age	-0.04	-0.10***	-0.09	-0.08*	-0.12***	-0.05	0.04	0.05
Education	-0.03	0.16***	-0.04	-0.01	-0.06*	0.08**	-0.01	-0.04
R^2	0.01	0.04***	0.02***	0.01*	006***	0.03***	0.01*	0.04***

* $p < .05$; ** $p < .01$; *** $p < .001$;

Table 14: *Multiple regression analyses for verbal communication and time: Beta coefficients R^2 and P values*

	Verbal communication	Preference for physician's spoken language (6)	Time	Needs for more time to get acquainted with physician (32)
Patient and physician culture	-0.27***	0.12***	-0.04	0.00
Gender (1=Male)	-0.03	-0.04	0.05	0.00
Marital Status (1=Married)	-0.03	-0.04	0.03	0.06*
Age	0.15***	0.18***	-0.11***	-0.12***
Education	-0.05	0.10***	0.07*	-0.10***
R^2	0.10***	0.06***	0.02***	0.03***

* $p < .05$; ** $p < .01$; *** $p < .001$

5.3 Analysis and results of multiple regressions

For the purpose of summarizing the results of the study, multiple regressions were performed, in which the dependent variables were the needs, attitudes, expectations, and satisfaction of patients in the medical encounter, and the independent variables were patient gender, patient age, culture (congruence or incongruence with physician culture as a dummy variable ranging 0-1), patient education, and patient marital status (married/not married as a dummy variable ranging 0-1). The results are summarized in Tables 13 and 14 and outlined below.

Information-seeking and giving: The regression for information-seeking and giving as a criteria variable was found to have a low percentage of variance (R^2=0.01)

Participatory decision-making: Patients from culture-congruent groups expressed less desire to take part in PDM. As patient age rises, the desire for PDM decreases. As education level rises (more years of study), the desire for PDM rises as well. The examined predictors explain 4% of the variance for desire for PDM.

Physician's interpersonal communication: Patients from culture-congruent groups evaluated their physicians' interpersonal communication more positively than did patients from culture-incongruent groups. As patient age rises, evaluation of the quality of physician's interpersonal communication decreases. As patient education level rises (more years of study), the evaluation of physician's interpersonal communication decreases. The examined predictors explain 6% of the variance for physician's interpersonal communication.

Patient's satisfaction with the physician's courtesy (35): Patient satisfaction with physician courtesy is explained by the congruence between the culture of the patient and that of the physician. Satisfaction was found to be higher in culture-congruent dyads. The examined predictors explain 4% of the variance for patient satisfaction with physician courtesy.

Verbal communication: Patients from culture-incongruent groups reported more problems deriving from language barriers than did patients from culture-congruent groups. As patient age rises, reports on language problems increase. The examined predictors explain 10% of the variance for problems deriving from language barriers.

Patient preference for physician language (6): Congruence between patient and physician culture, age and education was found to predict statistically significant differences in the preferences of patients to be examined by physicians who speak their own languages. Patients from culture-congruent dyads preferred physicians speaking their own languages. As patient age and education levels rise, patient desire to be treated by physicians speaking their own language increases as well. The examined predictors explain 6% of the variance for preferences for physician's spoken language.

Time: As patient age rises, problems of lack of time during the medical encounter decrease. When patient education level rises, problems of lack of time during the medical encounter increase. The examined predictors explain 6% of the variance for lack of time during the encounter.

Although some variables were found statistically significant in the regressions, the highest percentage of explained variance was R^2=0.10.

5.4 Additional data

Additional data collected during the study were not directly correlated to the examination of the hypotheses yet were considered to enrich the findings. The variable of gender was examined to explore female and male patients' preferences regarding physician gender. The statement regarding the Internet search for medical information was tested for an enhanced understanding of patient information-seeking behaviours. The translator's identity statement was separated from the sub-scale of verbal communication and examined separately in order to explore AI and FSU immigrant patients' preferences regarding the identity of translators.

5.4.1 Gender (statements 37, 38, 39)

Table 15: *Differences between male and female patients regarding preferences to be examined by physicians of their own or opposite gender, processed according to patient culture (Statement 37)*

	Patient culture					
	Jewish-Israeli		Arab-Israeli		FSU immigrant	
	Patient gender		Patient gender		Patient gender	
	Male	Female	Male	Female	Male	Female
The opposite gender	0.6%	10.3%	2.4%	0.6%	3.0%	10.2%
Same gender	17.6%	9.1%	12.1%	19.4%	10.4%	16.3%
Doesn't matter	81.8%	80.6%	85.5%	80.0%	86.6%	73.5%
χ^2	18.69***		4.87		10.32***	

Table 15 shows a significant correlation between patient gender and preferences regarding treating physician gender for JI and FSU immigrant patients. Although over 73% of patients in all culture groups did not state a preference regarding physician gender, in the JI and FSU immigrant patient groups, a higher percent of male patients preferred physicians of their own gender (17.6% and 10.4% respectively) to physicians of the opposite gender. Female patients in these two culture groups preferred physicians of the opposite gender (10.3% and 10.2% respectively). In other words, both male and female patients in these two culture groups expressed a preference for male physicians. No statistically significant preference was found among AI patients regarding physician gender.

Table 16: *Differences between male and female patients regarding their preferences to talk about medical problems with physicians of their own or opposite gender, processed according to patient culture (Statement 38)*

	Patient culture					
	Jewish-Israeli		Arab- Israeli		FSU immigrant	
	Patient gender		Patient gender		Patient gender	
	Male	Female	Male	Female	Male	Female
The opposite gender	0%	9.7%	1.8%	3.6%	2.4%	10.8%
Same gender	16.4%	9.1%	17.0%	18.8%	14.6%	16.3%
Doesn't matter	83.6%	81.2%	81.2%	77.6%	82.9%	72.9%
χ^2	19.48***		1.29		9.95**	

** $p < .01$; *** $p < .001$

Table 16 shows differences among female patients from the three culture groups. AI female patients expressed a decreased preference to talk about medical problems with physicians of the opposite gender (3.6%) compared to JI and FSU immigrant female patients (9.7% and

10.8% respectively). AI and FSU immigrant female patients expressed an increased preference to talk about medical problems with physicians of the same gender (18.8% and 16.3% respectively) compared to JI female patients (9.1%). No statistically significant difference was found between JI and AI female patients regarding lack of preference. A lower percentage of FSU immigrant female patients reported a lack of preference (72.9%), as compared to both JI and AI female patients. No statistically significant difference was found between male patients of the three culture groups on this statement.

Table 17: *Differences between male and female patients regarding their preferences to talk about emotional problems with physicians of their own or opposite gender, processed according to patient culture (Statement 39)*

	Patient culture					
	Jewish-Israeli		Arab- Israeli		FSU immigrant	
	Patient gender		Patient gender		Patient gender	
	Male	Female	Male	Female	Male	Female
The opposite gender	2.4%	7.3%	6.1%	4.2%	4.9%	9.0%
Same gender	12.7%	20.6%	15.8%	30.9%	14.0%	16.9%
Doesn't matter	84.8%	72.1%	78.2%	64.8%	81.1%	74.1%
χ^2	8.77*		10.70**		3.00	

*p < .05; ** p < .01

Table 17 shows a correlation among JI and AI patients between patient gender and preference to discuss emotional problems with physicians of their own or opposite gender. A high percent of JI (20.6%) and AI (30.9%) female patients felt more comfortable discussing emotional problems with female physicians. A high percent of JI (84.8%) and AI (78.2%) male patients reported no preference regarding this statement.

5.4.2 Patients' use of Internet search and other sources for information (statement 40)

Table 18: *Frequency distribution in percentages of patients' search on the Internet and other sources according to patient culture and education levels (Statement 40)*

		Patient culture						Total	
		Jewish-Israeli		Arab-Israeli		FSU Immigrants			
		n	%	n	%	n	%	n	%
All culture groups									
	yes	79	23.9%	35	10.6%	31	9.4%	145	14.6%
	no	229	69.4%	273	82.7%	221	67.0%	723	73.0%
	other	22	6.7%	22	6.7%	78	23.6%	122	12.3%
Educational level									
0-9 years									
I search the Internet...	yes	0	.0%	4	3.2%	0	.0%	4	2.2%
	no	30	90.9%	118	93.7%	16	84.2%	164	92.1%
	other	3	9.1%	4	3.2%	3	15.8%	10	5.6%
Total		33	100.0%	126	100.0%	19	100.0%	178	100.0%
10-12 years									
I search the Internet...	yes	31	17.4%	18	12.7%	7	10.0%	56	14.4%
	no	140	78.7%	112	78.9%	53	75.7%	305	78.2%
	other	7	3.9%	12	8.5%	10	14.3%	29	7.4%
Total		178	100.0%	142	100.0%	70	100.0%	390	100.0%
13+ years									
I search the Internet...	yes	48	40.3%	13	21.7%	24	10.0%	85	20.2%
	no	59	49.6%	41	68.3%	152	63.1%	252	60.0%
	other	12	10.1%	6	10.0%	65	27.0%	83	19.8%
Total		119	100.0%	60	100.0%	241	100.0%	420	100.0%

Dependent variable: I search the Internet for more information about my medical problem

Table 18 reveals that among JI patients, nearly a quarter (24%) searched the Internet for additional medical information and 7% of patients searched other sources. Among AI patients, 11% searched the Internet, while 7% referred to other sources. Among FSU immigrant patients, 9% searched the Internet and 24% searched other sources. 69% of the JI patients did not search for additional written information. 83% of AI patients reported not to have searched for additional information, and 67% of FSU immigrant patients did not search for more information (χ^2= 87.27, p< .001). These results suggest that JI patients demonstrated an increased desire to search for medical information on the Internet, while FSU immigrant patients were more inclined to search in other sources.

Since the variable of patient education (years of study) was suspected to affect patient desire to seek medical information on the Internet, three levels of education were tested separately: 0-9 years of study, 10-12 years of study, and 13+ years of study.

Results showed that among patients of the three culture groups belonging to the elementary education level (0-9 years), almost none of the patients searched the Internet (2.2%), and most of them did not search for further information at all (92.1%), (χ^2=7.36, p = NS). Among patients from the three culture groups belonging to the secondary education level (10-12 years), 17% of JI patients searched the Internet, while around 80% did not search for additional information at all; 13% of AI patients searched the Internet, while about 80% did not search at all; among FSU immigrant patients about 10% searched the Internet, while around 76% did not search at all. At this education level, the correlation between culture and source of information search was found to be statistically significant (χ^2=9.98, p = .05). Among patients from the three culture groups belonging to the higher education level (13+ years), 40% of JI patients searched for medical information on the Internet, 50% did not search at all, and 10% turned to other sources. 22% of the AI patients searched the Internet, 68% did not search at all, and 10% searched in other sources. Among FSU immigrant patients, 10% searched the Internet, 63% did not search for additional information at all, and 27% turned to other sources.

These findings suggest that the variable of education combined with culture affects patient use of additional information sources. JI patients were more inclined to search the Internet than were patients from the other two culture groups, and their tendency to search the Internet increased as their education level rose. FSU immigrant patients searched more in other sources, and AI patients searched less than patients from the two other culture groups, yet as their level of their education increased, they were more inclined to search in other sources.

Table 19: *Frequency distribution in percentages of patients searching the Internet and other sources according to patient gender and education levels (Statement 40)*

		Male		Female		Total	
0-9 education yrs							
	yes	2	2.8%	2	1.9%	4	2.2%
I search the Internet...	no	63	88.7%	101	94.4%	164	92.1%
	other	6	8.5%	4	3.7%	10	5.6%
Total		71	100.0%	107	100.0%	178	100.0%
10-12							
	yes	32	14.7%	24	13.9%	56	14.4%
I search the Internet...	no	165	76.0%	140	80.9%	305	78.2%
	other	20	9.2%	9	5.2%	29	7.4%
Total		217	100.0%	173	100.0%	390	100.0%
13+							
	yes	43	20.8%	42	19.7%	85	20.2%
I search the Internet...	no	136	65.7%	116	54.5%	252	60.0%
	other	28	13.5%	55	25.8%	83	19.8%
Total		207	100.0%	213	100.0%	420	100.0%

Dependent variable: I search the Internet for more information about my medical problem.

Table 19 shows that in examining the correlation between gender and information search, no statistically significant differences were found between patient gender and patient attitude toward searching for additional medical information on the Internet and in other sources. However, when the correlation was tested separately for the three education levels, the results showed that female patients with a higher education level (13+ years of study) searched for information in other sources more than did male patients of the same education level (26% of female patients vs. 13.5% of male patients). As education level rises, an increased desire to search the Internet was found among both male and female patients.

Table 20: *Frequency distribution in percentages of patients' search on the Internet and other sources according to patient gender and culture (Statement 40)*

			Patient culture					
			Jewish-Israeli		Arab-Israeli		FSU Immigrants	
			n	%	n	%	n	%
Male								
	I search the Internet...	yes	46	27.9%	17	10.3%	14	8.5%
		no	105	63.6%	134	81.2%	125	75.8%
		other	14	8.5%	14	8.5%	26	15.8%
	Total		165	100.0%	165	100.0%	165	100.0%
Female								
	I search the Internet...	yes	33	20.0%	18	10.9%	17	10.3%
		no	124	75.2%	139	84.2%	96	58.2%
		other	8	4.8%	8	4.8%	52	31.5%
	Total		165	100.0%	165	100.0%	165	100.0%
Total								
	I search the Internet...	yes	79	23.9%	35	10.6%	31	9.4%
		no	229	69.4%	273	82.7%	221	67.0%
		other	22	6.7%	22	6.7%	78	23.6%
	Total		330	100.0%	330	100.0%	330	100.0%

Dependent variable: I search the Internet for more information about my medical problem.

Table 20 reveals that the percentages of male and female patients from the three culture groups who searched the Internet were similar (JI male patients 28%, JI female patients 20%; AI male patients10%, AI female patients 11%; FSU immigrant male patients 8.5%, FSU immigrant female patients 10%). A statistically significant difference was found between male and female FSU immigrant patients regarding searching for information in other sources (16% among male FSU immigrants, and 31.5% among female FSU immigrants (χ^2=12.76, p<.01).

5.4.3 Arab-Israeli and FSU immigrant patients' preferences regarding identity of translators (statement 44)

To examine whether AI and FSU immigrant patients preferred to receive translation from people other than their family members, a chi square test was conducted. The Likert scale of patient answers to statement 44 were recoded into two categories: patients who indicated their answers as "totally disagree" (1), "agree mildly" (2) and "agree moderately" (3) were recoded as "1", while patients who indicated their answers as "agree very much" (4) and "agree totally" (5) were recoded as "2".

Table 21: *Differences between Arab-Israeli and FSU immigrant patients regarding their preferences to have family or others translating in the medical encounter*

		Patient culture				Total	
		Arab-Israeli		FSU Immigrants			
		n	%	n	%	n	%
I would like to have someone else translate in the visit, rather than my family member	1	52	89.7%	118	82.5%	170	84.6%
	2	6	10.3%	25	17.5%	31	15.4%
	Total	58	100.0%	143	100.0%	201	100%

Table 21 shows that ca. 90% of AI patients and 82.5% of FSU immigrant patients did not prefer others to their family as translators (χ^2=1.8, p = NS).

Chapter 6 Discussion

In recent years, medical providers have faced the challenge of caring for patients from a variety of cultures who speak different languages, are on different acculturation and socioeconomic levels, and have unique culturally-based ways of understanding illness, health, and health care. Immigrants worldwide commonly report feeling misunderstood by their doctors. This is not only due to language barriers but also to differences in their definitions of illness and their beliefs about health and health behaviours. For example, in the US and the UK minority patients were troubled not only by the outcomes of biomedicine but by the manner of its delivery, particularly when their cultural traditions differed from those of their physicians (Madhoc 1992, Hahn 1995).

Today, broad cultural concepts have begun to be used by physicians to understand and empathize with their patients' beliefs, values and worldview in order to discover what solutions are in the best interests of the patient. As in every multicultural society, Israeli physicians are facing the challenge of understanding the impact of each patient's cultural background on health beliefs and behaviours, in order to effectively communicate and overcome relationship barriers.

The current study assesses differences between Jewish-Israeli (JI), Arab-Israeli (AI), and FSU immigrant patients regarding their values, attitudes, needs and satisfaction in the medical encounter, and their assessment of health care providers. The general picture that emerges from the data demonstrates the diversity of present practice in Israel, and the impact of these differences on patients' evaluations of the various aspects of the medical encounter examined in the study.

6.1 Characteristics of the study sample

The population studied was composed of randomly selected ambulatory patients from the three culture groups, 330 patients in each group. FSU immigrant patients were older and better educated, and reported a higher need for translation than AI patients. However, 11.5% of AI patients also required translation assistance, mostly females.

AI patients' lower Hebrew proficiency may be due to several reasons. AI citizens are usually educated in Arab-speaking schools, with Hebrew as a second language. AI patients were also found to have fewer years of study compared to JI patients. According to Israel Central Bureau of Statistics data for 2003, 36.8% of JI citizens completed 11-12 years of education (37.6% males and 36% females), compared to 32.4% of AI citizens (34.5% males and 30.2%

females). At the level of 16+ years of education, the differences are more pronounced, with 19.5% of the JI population (20% males and 19% females) compared to 8.4 % of the AI population (9.7% male and 7.1% females). In addition, AI female patients living in rural villages usually do not work with or communicate with JI citizens in their daily lives, and therefore have a lower Hebrew proficiency than males.

In all three culture groups the primary accompanying persons were family members. Almost half of the AI patients were accompanied by another person. Close family relations are typical of the three culture groups. In the Jewish population family cohesion remains relatively strong despite growing modernization and secularization. This has important implications with regard to informal social support, ability to cope with stress, tenacity of family-based lifestyles, and social control. Israel has been referred to as a familial society (Shuval 1992), which may explain why JI patients bring family members to the medical encounter.

Researchers argue that Arab culture emphasizes the *hamula* (kinship group) as a predominant value, so that the Arab family remains patrilineal, patrilocal, patriarchal, and endogamous. While the values of conservatism and traditionalism in the nuclear family have been influenced by contact with Jewish society and by modernization, researchers have noted that contact with Jewish society failed to change Muslim men's position regarding the status of women, and indeed reinforced their traditional beliefs that women may jeopardize their honour (Shokeid 1980, Patai 1983, Al-Haj 1989). According to Ginat (1982), for AI women unaccompanied movement within the village and certainly outside it was restricted in the past, though freedom of movement has increased in recent years. Many of the restrictions on Arab Muslim women reflect the modesty code. A married woman is not only protected and offered shelter by her agnates, but is also supervised and controlled by them. Rispler-Chaim (1993) explains that when the doctor and patient are of opposite sexes, their being alone in a clinic evokes the problem of the *khalwa* (seclusion), which only married couples or persons who have specific blood ties may enjoy. In order to avoid unnecessary cases of *khalwa*, Muslims would often recommend the presence of a nurse, a female relative or the husband of the patient in the encounter, while the male physician examines a woman. This may explain why AI women are escorted to medical encounters by their husbands or other family members. An additional reason may be that AI females need translation assistance due to lower Hebrew proficiency.

FSU immigrant patients may bring escorts to the medical encounter for a combination of reasons. Poor command of Hebrew, especially among the elderly, may partly explain why patients bring relatives or friends. Another explanation may refer to immigrants' age. There are relatively more elderly persons among immigrants than among the veteran Jewish

population. The elderly, who tend to be sicker and suffer from chronic diseases, may find it physically difficult to come to medical encounters on their own. Moreover, FSU immigrants' social networks are ethnically-centred and composed mainly of other immigrants who came during the same immigration wave (Al-Haj 2000). Hence, their dependency on family and other immigrant friends combined with language barriers and reduced health status may explain why they come with escorts to the medical encounter.

Since patients in all three culture groups tend to bring escorts to medical encounters, physicians should be aware of the potential change in the visit's dynamics from an exchange between physician and patient to a physician-patient-family negotiation process (Putsch 1985). Another consideration is the role of the accompanying persons as translators. Results showed that the majority of AI patients and FSU immigrant patients did not prefer others over their family members as translators. Patients who were interviewed in-depth emphasized the importance of a translator's presence, and did not mind speaking of their medical and personal problems in the presence of family members. The goal of mutual understanding with the physician seemed to override feelings of shyness or embarrassment. Nevertheless, physicians should take into account the disadvantages and potential problems that arise from using family members as interpreters. The research evidence suggests that trusted bilingual family members and friends are often ill-prepared to deal with the complexity of interpreting, may have conflicts about revealing information the patient has not volunteered, may commit stereotypical errors that may result in serious distortions, and may not stop their own views from colouring their translation. In addition, the patient may be inhibited from discussing embarrassing issues in front of family members, especially children and friends (Fuller 1988, Ebden 1988, Phelan 1995, Baker 1998, Dwyer 2001, Ngo-Metzger 2003). Researchers expressed serious concerns about using children to interpret for fear of exposing them to sensitive information and upsetting family dynamics (Rack 1982, Putsch 1985, Baker 1998, Woloshin 1995, Cohen 1999).

6.2 Dimensions of cultural variability

The cultural variability schemas of *individualism-collectivism, low-and high-context* communication, and time orientation (*M-time and P-time*) are used to interpret differences between the three culture groups. For a detailed discussion of these cultural variability schemas, see Chapter 2.

Based upon these models of cultural variability, Jewish-Israeli patients can be defined as members of an individualistic culture who have a low-context, direct and exacting verbal style and use M-time. Arab-Israeli patients belong to a collectivist culture, use a high-context,

elaborate and affective communication style, and follow P-time. FSU immigrant patients brought their own unifying language and a shared world of values and symbols derived from the social-control mechanism woven into Russian and Soviet culture (Leshem 1999), which places them on the collectivistic end of the individualism-collectivism dimension. Upon their arrival in Israel, they found themselves in a political and social system where individualistic values such as personal initiative and responsibility are stressed, and they have become proficient in using the system to obtain needed services. Al-Haj (2000) claims that the immigrants' views of courtesy, individual rights and other issues connected with multicultural perception are based on instrumental and pragmatic rationales according to their group and individual interests rather than on universal measures and values. Most immigrants have adopted a "multidimensional type" of identity combining the Jewish component with the ethnically-centred component and the ideologically-centred Zionist component. The importance of ethnic identity among immigrants is reflected in their deep cultural pride and even in their sense of cultural superiority to Israeli society. Thus, FSU immigrants may be characterized as acculturating into the absorbing, individualistic Jewish-Israeli culture while continuing to demonstrate attitudes largely based on the value system of the Soviet regime. According to Gudykunst (1988) the USSR is considered to be a culture that uses a low-context communication style, which may also place the FSU immigrants as following M-time.

While JI culture is placed as individualistic, certain additional traits of Israeli culture should be taken into account. Katriel (1991) has explained that a central aspect of the Israeli experience is the weaving of shared communal bonds. The notion of connectedness has dominated the Israeli nation-building ethos, and is still encouraged today in army service, at school, at religious rituals, and in other organizations. Contrary to the American "celebration of the self", a profound communal focus still dominates Israeli culture despite the much discussed "Americanization of Israel" (Katriel 1991). Sered (1999) claimed that Israeli culture is less hierarchical than many other Western societies and addressed another related element of the Israeli cultural ethos, "prickliness", brashness, or assertiveness, as expressed in referring to a native Israeli as a "*tsabar*" (the cactus fruit, which is prickly outside and sweet inside). This assertiveness, together with Israeli's non-hierarchical cultural ethos, means that in everyday interactions individuals are expected to challenge others' opinions, stand up for their own opinions, and speak their minds freely. These characteristics correlate with Katriel's (1986) assessment of Israeli Sabra culture as a low-context culture that uses "straight talk", a direct verbal style.

Interactions across low-and high-context boundaries are particularly prone to confusion (Ting-Toomey 1985). Thus, culture-incongruent dyads, as for example JI patient-AI physician or FSU immigrant patient-AI physician, bring together individuals who hold individualistic versus collectivistic views and values, differ in their concept of time and use different communication styles, all of which may cause misunderstandings and mutual frustrations.

6.3 The first hypothesis

As the first hypothesis suggested, patients in the three culture groups on the whole differed in their values, beliefs, attitudes, expectations, and behaviours, all of which were found to impact their evaluations of the examined aspects in the medical encounter and of their physicians.

JI patients expressed needs and exhibited behaviours that may be interpreted as individualistic and consumerist, and assumed more bargaining power in the relationship with the medical provider. Compared to both AI and FSU immigrants, JI patients were found to seek and receive more medical information, and expressed an increased desire to become partners in PDM. These findings correspond with Baider's (1995) reports of greater desire for information and participation in treatment planning among Israeli cancer patients compared to FSU immigrants. JI patients also expressed more desire to consult with additional sources, including family members, friends and religious clerics. This desire may also reflect a consumerist attitude in which the physician is viewed as a consultant whose opinions are listened to, but ultimately the decision is up to the patient. As members of the dominant culture group, JI patients are probably more familiar with current modernization trends in the Israeli medical system, and seem to want to benefit from patient-centred and consumerist approaches that support individual goals and needs. Their physicians seemed to demonstrate behaviours promoted by these approaches that matched their patients' needs and expectations.

JI patients were more satisfied than either of the other two culture groups with the interpersonal communication style, the medical treatment and courtesy provided by their physicians, and they expressed less desire for improvements. The fact that JI patients did not suffer from language barriers and did not report on lack of time may have contributed to their greater satisfaction than AI and FSU immigrant patients who were burdened by such barriers. These results resemble the higher satisfaction rates reported for whites in the US compared to minority group patients such as African-Americans, Hispanics, and Mexican-Americans, who were found to receive less information and to have less participatory visits, resulting in lower levels of satisfaction (Kaplan 1995, Blackhall 1995, Maly 2003). Malat (2001) explained that whites have an advantage in that they view themselves as the norm in American society, thus

helping them dismiss the possibility that the health care provider views them negatively, resulting in a more favourable feeling about the interaction. Similar traits may be attributed to JI patients.

JI patients interviewed in-depth seemed more realistic regarding physicians' interpersonal communication style than were their counterparts in the other culture groups. They did not emphasize the need for personal discussions, which was mostly left up to the physicians. This may be attributed to the individualistic, target-oriented goal of coming to see the physician for a medical purpose and using the available limited time for this purpose only. Nevertheless, when describing the "ideal" physician, these patients considered a personal and compassionate attitude as crucial and as important as professional knowledge. This description is supported by Pendleton's (1983) findings correlating patient satisfaction to physician communication characteristics, including discovering and dealing with patients' concerns and expectations with warmth, interest and concern, and volunteering a lot of information in terms that are understood by patients. Baider (1995) also suggested that JI patients expect a close relationship with their physicians based on trust and on the ability to talk openly and freely to the physician when problems arise.

Comparing the AI minority group with the FSU immigrant group showed that AI patients were on the whole more satisfied with the visit, sought and received more medical information, and evaluated the physician's interpersonal communication style more positively. These results may suggest similar basic needs and behaviours among AI and JI patients compared to FSU immigrants, particularly in their information-seeking behaviours and their evaluation of physicians' interpersonal communication. AI patients are more acculturated into the dominant JI culture than are FSU immigrant patients, and are more familiar with the Israeli health care system. Nevertheless, compared with JI patients, AI patients expressed greater need for improvement in the medical encounter. This may be the result of problems and misunderstandings deriving from differences between individualistic and collectivistic cultures, differences between high and low context communication, and different approaches to time orientation. It may also be related to language barrier problems as well as to the minority status of Arab Israelis, which may lead to underlying tensions in examinations by JI and Russian-Israeli physicians.

AI patients exhibited unique cultural and religious attitudes, needs, and behaviours regarding the roles of all participants in the medical encounter: the patient, the family, and the health care practitioner. As Ali (1993) noted with Egyptian cancer patients, Muslim as well as Christian patients in Egypt believe that humans should not question God's decision, but should accept and endure the consequences. The physician is considered an authority in

treating diseases, and whatever is prescribed should be followed precisely. Thus, the patient is expected not to contradict or question the physician, which would imply impolite behaviour or lack of respect. Moreover, emotional support is the responsibility of the family, not of the health care practitioner. Rispler-Chaim (1993) studied the Islamic Code of Medical Ethics, which was drawn up at the First International Conference on Islamic Medicine in Kuwait in 1981. In her view, it implied that the reference to Allah (God) and the recognition by every Muslim that there is a divine God who supervises all things including the actions of doctors, are likely to engender greater humility in doctors, more careful practice, and hence more ethical medicine. Similar traits among Muslim, Druze and Christian patients were reflected in the in-depth interviews and the field study results. AI patients trusted their physicians to have all the necessary knowledge and information. They were therefore satisfied with the provided information, and left treatment decisions to their physicians.

FSU immigrant patients reported less information-seeking behaviour, less information-giving by physicians, a lower desire for PDM, and less willingness of physicians to engage in PDM. Similar results were reported by Baider (1995). These results may indicate confusion among FSU immigrant patients regarding the differences between the Western host medical system and the socialist Soviet system. Medical care in the FSU adhered to an authoritarian and paternalistic philosophy of care, leaving little room for free exchange of information. Doctors made "informed decisions" for their patients, while little choice was offered to patients and compliance was required (Sloane 1991, Brod 1992, Remennick 1998). FSU immigrant patients seemed to conform to the Russian model of medical care; nonetheless, their dissatisfaction may express a conflict between their desire to benefit from modern Western Israeli health care and their inability to behave accordingly.

FSU immigrant patients' expressed need for improvement in the medical encounter may be accounted for by several reasons: (1) they suffered more language problems and lack of time than did JI patients, leading to impaired communication, misunderstandings and frustration, and resulting in reduced satisfaction. Patients interviewed in-depth reported that language barriers and shortage of time prevented them from receiving sufficient information, asking questions, understanding physicians and making themselves understood, and carrying out personal conversations with physicians. Similar results were reported with minority patients in the US, such as Hispanic Spanish-speaking patients in non-concordant physician-patient dyads (Kaplan 1989, Woloshin 1995, David 1998, Perez-Stable 1997, 2000). This explanation is also supported by FSU immigrant patients' preference to be examined by physicians speaking their own language. (2) Another explanation relates to the differences between the Russian and Israeli health care systems. In the FSU, strong emphasis was placed on medicine

as a "helping profession", where primary physicians functioned as informal psychotherapists who showed concern and gave hope and guidance. Many doctors served their neighbourhood for years, ensuring familiarity with patients and continuity of care. Many patients believed that Soviet doctors showed more sympathy and warmth, probably because Israeli physicians are not willing to act as counsellors as did Soviet doctors. Many FSU patients, particularly the elderly, were also disappointed that house calls, which were central to Russian health care, are not available in Israel (Bernstein 1994, Remennick 1995, 1997). (3) In the US, older FSU immigrant patients were found to have unrealistically high expectations of the American medical system, expecting the doctors to make them well immediately (Brod 1992). Similarly, Remennick (1995) reported unrealistic expectations; the belief that Israeli advanced medicine promises a cure for all sufferers led to disappointments. (4) FSU immigrants may rely on old habits and operate under expectations that are regarded as inappropriate in their new environment. In the FSU, they were accustomed to having to "make noise" to get anything and became proficient in "working the system" to obtain needed services. In the US, physicians described such behaviours as pushy, manipulative, and abrasive (Wheat 1983, Brod 1992). Physicians in Israel may have similar feeling toward such behaviours, which may result in impaired communication, reduced willingness and courtesy, and lower patient satisfaction. (5) Results of the study's multiple regressions revealed that older patient age and higher education level negatively influenced patients' evaluation of physicians' interpersonal communication style. FSU immigrant patients were older and better educated than patients in either of the other culture groups, which may partly account for their lower evaluation of physician's communication style and courtesy.

Most AI and FSU immigrant patients interviewed in-depth wanted to befriend their physicians, and felt that personal conversations enhanced their trust in the physicians and improved the atmosphere of the encounter. Both AI and FSU immigrant interviewees reported that discussions of personal issues and the chance to become friends with physicians were mainly possible with culture-congruent, language-concordant physicians.

The reasons for this desire to befriend physicians seemed to differ between the two patient groups. AI patients, as members of a collectivistic culture, may have wanted to befriend their physician to maintain harmony. Due to their high-context verbal communication, they may not display their needs directly. Thus, the negotiation process with the physician is long-term, arguments or disagreements in a conflict situation are expressed ambiguously, and eventual reciprocity of face-honouring is important in maintaining social and personal relations (Ting-Toomey 1988, Gudykunst 1988). Similar reports from the US revealed that African-American patients expressed desire to build a relationship with physicians before invasive testing, based

perhaps on the belief that a doctor must know a patient to provide good medical care and that a relationship with a physician is a good foundation for trust. By contrast, white patients expressed a desire for receiving information without the need of knowing the physician (Collins 2002).

AI patients interviewed in-depth wished to have a personal discussion first to create a pleasant atmosphere before getting into the medical details of their problems. This desire corresponds to the need for more time to get acquainted with the physician reported in the field study. As members of a collectivistic culture following the P-time pattern, AI patients may tend to have more flexible attitudes toward appointment schedules and to integrate task needs with socio-emotional needs. This may explain their emphasis on human connectedness and desire to establish friendly relations with physicians.

FSU immigrant patients seemed to crave their physicians' attention and friendship in order to share their absorption problems and difficulties of daily life as immigrants. This desire was reflected in Habermas' (1984) theory of communicative action that posits a dialectical struggle between value rationality and the voice of the lifeworld, that is, the contextually grounded experiences of everyday events. Mishler (1984) claimed that science-based medicine suppresses patients' meaningful accounts so that encounters become less humane and less effective. FSU immigrant patients' reported needs are consistent with research results supporting the premise that when both doctor and patient are engaged with the lifeworld, and patients are recognized as unique human beings, this leads to better outcomes and more humane treatment (Roter 1992, DeCoster 1997, Barry 2001).

The desire to meet with a friendly and caring physician was repeatedly and emotionally expressed by patients of the three culture groups who were interviewed in-depth. They all longed for physicians who would treat them as human beings, as a "*ben adam*". Although patients valued physicians' medical competence, they stressed the importance of the combination of knowledge and a humane approach. A physician's good word or a smile was believed to provide added value to any medicine and treatment. A similar emotional response was reported by Sered (1999) in interviews with Israeli breast cancer patients. A central theme in their narratives was the Hebrew word "*yachas*", loosely translated as "attitude", "attention" or "relationship". The women consistently and emotionally contrasted the good *yachas* of medical staff who treated them "like humans" or "real friends" with the bad *yachas* of staff who treated them like numbers, broken-down machines or strangers.

JI patients expressed more desire to consult with a religious cleric, a rabbi than did AI patients. Muslim, Christian and Druze AI patients who were interviewed in-depth, all reported

that they turn to their sheikh or priest only for prayer or spiritual relief but not for medical advice, because they trust physicians to have the medical knowledge. As discussed earlier, similar traits were described by Ali (1993). The percentage of patients who expressed a desire to consult with family members was found similar in all three culture groups, which matches the central role of the family in the three cultures discussed previously.

The increasing use of the Internet as a rich source of information, including medical, has led to the assumption that patients looking for additional information will also search the Internet. Nearly a quarter of JI patients searched the Internet, compared to 11% of AI patients and 9% of FSU immigrant patients, while FSU immigrant patients reported an increased desire to search for medical information from other sources. Several explanations may account for these findings. JI patients were found to seek and receive more medical information and express a greater desire to consult with additional sources than either of the other two culture groups. This may reflect a modernistic health consumerist attitude of members of an individualistic culture that challenge physicians' knowledge (Beck 1994, Lupton 1997). The Internet may serve as a source of information for JI patients who seek active involvement in discussions and decisions about their health. JI patients may also have better access to the Internet due to a higher economic status, and better proficiency in Hebrew and English compared to the other two culture groups. The lesser desire of AI patients to search for additional information may also refer to their increased trust and respect for physicians' knowledge. FSU immigrant patients interviewed in-depth reported searching for information in various alternative medicine sources, also reported as a popular source in Russia by Cassileth (1995) and Lidquist (2001).

Patients in the three culture groups on a higher education level were more inclined to search the Internet and other information sources. This finding may reflect improved economical status and better understanding of written information. Female patients with a higher education level, regardless of culture, searched for information in other sources more than did male patients on the same education level. Providing information and PDM facilitation was associated with patient's female gender by Hall (1988) and Gotler (2000).

6.4 The second hypothesis

As the second hypothesis suggested, differences were found among patients of the three culture groups in their interaction with physician cultures. These differences were reflected in attitudes, needs, expectations, behaviours, and satisfaction.

6.4.1 Information

JI patients were found to seek and receive more information only from culture-congruent physicians. AI patients reported seeking and receiving more information when treated by JI and AI physicians than their counterparts seen by Russian-Israeli physicians. These findings may suggest that JI and AI physicians and patients share similar values and behaviours regarding patient information needs, as expressed by patients' increased desire for and physicians' increased willingness to provide medical information.

Russian-Israeli physicians, however, seemed to fall short when it comes to the needs of JI and AI patients. One explanation may be differences in training and shared values. JI and AI physicians were trained in the Israeli health care system and absorbed its current values of patients' rights and autonomy, as expressed in the Law of Patients' Rights (1996) and in the current promotion of patient-centred and consumerist approaches. Russian-Israeli physicians seemed to conform to the more paternalistic traits of the Russian health care system, which rarely promoted a free exchange of information (Sloane 1991, Brod 1992). FSU immigrant patients did not report on different behaviours regarding information-giving and seeking when visiting physicians from the three culture groups, corresponding with their overall reduced desire for information (as discussed in the examination of the first hypothesis).

6.4.2 Participatory decision-making

Similar findings were found regarding PDM facilitation. JI patients who visited Russian-Israeli physicians expressed an increased desire for PDM compared to their counterparts who visited both JI and AI physicians. They also reported that Russian-Israeli physicians were less open to PDM compared to JI physicians. The reasons for these findings may be similar to those mentioned regarding information. As reported by Barr (1996), it was not necessary for a Soviet physician to inform a patient of treatment risks, other treatment alternatives or poor prognosis. Even when a patient refused treatment, in many cases the physician would continue that treatment. By Western standards, these behaviours are seen as violating patients' rights.

AI patients expressed an overall lower desire for PDM, leaving decisions to the authority, trust and respect for their physicians' knowledge. This may explain their lack of differences regarding PDM regardless of physician's culture. FSU immigrant patients were also found to express a reduced desire for PDM. Nevertheless, when seen by JI physicians, they expressed an increased desire for PDM compared to their counterparts who visited Russian-Israeli physicians. This may reflect patients' expectations and desire to benefit from the modern

Israeli health care system through the conduct of their JI physicians. They expected more facilitation of PDM from JI physicians than from Russian-Israeli physicians, and may have been disappointed when their needs were not fulfilled.

FSU immigrant patients seen by AI physicians reported that their physicians were less open to PDM than did their counterparts seen by JI and Russian-Israeli physicians. Several explanations may account for this result. AI physicians may not be aware of FSU immigrant patients' desire for PDM due to language barriers. They may also hold stereotypical assumptions that FSU immigrant patients do not wish to take part in decisions due to prior experiences with FSU immigrant patients. JI physicians' willingness to facilitate PDM was probably due to their general attitude to comply with patients' needs regardless of culture. Russian-Israeli physicians' willingness may be attributed to lack of language barriers and better communication with culture-congruent patients, enabling them to better elicit patients' needs. Moreover, FSU immigrant patients' overall reduced desire for PDM may have been easier to meet as compared to JI patients' higher expectations.

6.4.3 Physicians' interpersonal communication

JI patients treated by Russian-Israeli physicians were found to express a greater need for improvement in the medical encounter than their counterparts who visited both JI and AI physicians. JI patients were also more satisfied with JI physicians' medical treatment and courtesy as well as with AI physicians' courtesy, compared to the conduct of Russian-Israeli physicians. These findings may imply that Russian-Israeli physicians are either unaware of or are not complying with the needs and expectations of JI patients, which are believed to be based on the current values of the Israeli health care system.

Taken together, these findings concerning an inferior evaluation of Russian-Israeli physicians' conduct are supported by substantial research evidence. Interviews, in which physicians demonstrated more patient-centred behaviour, actively sought the patient's point of view and enabled patients to openly express thoughts and questions were correlated with higher patient satisfaction rates. Emotional support was shown not only to bridge patient uncertainty regarding treatment content and outcome, but also to be a crucial element in patients' evaluation of the treatment itself (Ben-Sira 1980, Stewart 1984). Patient satisfaction has been related to the amount of information given by physicians, greater technical and interpersonal competence, more partnership building, more social conversation, more positive talk, and more communication overall (Hall 1988, Laine 1996). Thus, JI patients' less positive evaluation and dissatisfaction with Russian-Israeli physicians' behaviours may be correlated

to Russian-Israeli physicians' lesser provision of medical information and accommodation of PDM and their paternalistic, non-supportive conduct.

AI patients evaluated both JI and AI physicians' interpersonal communication and courtesy more positively than that of Russian-Israeli physicians. Moreover, AI patients seen by Russian-Israeli physicians also expressed more need for improvement in the medical encounter compared to their counterparts who were seen by culture-congruent physicians. The similarity of results concerning JI and AI patient reports on this aspect may suggest that patients of both culture groups share similar expectations when visiting physicians. JI and AI physicians seemed to understand and conform to these needs, while Russian-Israeli physicians seemed to misinterpret or ignore them.

As discussed earlier, AI patients more than JI patients seem to respect physicians' authority as knowledgeable scholars and as decision-makers regardless of physician culture. In light of this respectful attitude, their lower evaluation and dissatisfaction with Russian-Israeli physicians seem even more striking. Several of the reasons mentioned for JI patients' less positive evaluation of Russian-Israeli physicians' behaviours seem applicable to AI patients' reports as well: a more paternalistic approach, less information-giving and less willingness to deal with patients' concerns.

Additional reasons for AI patients' complaints may be due to problems deriving from language barriers when examined by language non-concordant physicians. The common language used between in the AI patient-Russian-Israeli physician dyad is Hebrew, which is not the mother tongue of the physicians or of the patients. In some encounters translators were not available, and in others translators were untrained, for example patients' family members or medical staff. Even interpreted encounters may not suffice to overcome problems caused by language barriers, such as misinterpretations and misunderstandings of both parties. Another problem may lie in cultural variability of verbal communication styles. The low-context, direct communication style of Russian-Israeli physicians vs. the high-context, elaborate verbal style of AI patients may have also caused mutual misinterpretations and frustrations.

Use of an elaborate, affective and indirect style by AI patients may not only have been misunderstood by Russian-Israeli physicians, it may also require extra time to elicit patients' problems and requirements. Indeed, AI patients seen by Russian-Israeli physicians reported suffering more from lack of time than their counterparts who visited JI and AI physicians. They also expressed a greater need for more time to get acquainted with the physician. It seems that Russian-Israeli physicians did not allocate the extra time needed to meet AI

patients' needs and desires. Finally, the political-economical tensions between the AI population and the FSU immigrants cannot be ignored, and may have had further impact on AI patients' reports (see chapter 1.2.4: background).

FSU immigrant patients who visited Russian-Israeli physicians evaluated physician's interpersonal communication more positively than did their counterparts who were treated by both JI and AI physicians. In particular, patients treated by AI physicians had more negative evaluations than those seen by JI physicians. In addition, FSU immigrant patients were more satisfied with the courteous behaviour of Russian-Israeli physicians than with the conduct of JI physicians. These results are consistent with reports of FSU immigrant patients' complaints of a lack of friendliness by physicians in the Israeli health care system, describing them as "dry", "cold", or "indifferent" (Remennick 1995).

The reasons for the less positive evaluation of AI physicians may coincide with those discussed about the opposite dyad, the AI patient and the Russian-Israeli physician. Problems deriving from language barriers, use of different verbal communication styles, differences in time orientation, and the political-economical tensions between the two culture groups may have caused similar confusions, disappointments, and dissatisfaction in the FSU immigrant patient-AI physician dyad. Remennick (1995) suggested that FSU immigrant patients' dissatisfaction may at times express real differences between Israeli and Russian physicians, but may also be based on nostalgic memories of the past.

6.4.4 Language barriers

JI patients did not suffer from problems deriving from language barriers, as the spoken language in all the encounters was Hebrew. However, JI patients treated by AI physicians reported less desire to be examined by physicians speaking their own language than those seen by Russian-Israeli physicians. This may be partly explained by a lower Hebrew proficiency among Russian-Israeli physicians, but may also be interpreted as a critique of Russian-Israeli physicians, consistent with JI patients' overall less positive evaluation as described earlier.

AI patients treated by both JI and Russian-Israeli physicians suffered from language problems. As discussed earlier, AI patients reported lower Hebrew proficiency than JI patients, and 11.5% of AI patients, particularly female patients, needed and used interpreting assistance during the medical encounter.

FSU immigrant patients who visited both JI and AI physicians reported suffering from language problems. They also preferred to be examined by physicians speaking their own

language more than did either JI or AI patients. According to Remennick (1995), the main reason for FSU immigrant patients' choice of joining a particular health provider was accessibility of Russian-speaking physicians.

FSU immigrant patients reported lower Hebrew proficiency than their JI and AI counterparts, and they were older. The interrelation of these two variables was confirmed by Al-Haj (2000), who found a correlation between the various categories of fluency in Hebrew and immigrants' age and year of immigration. Improved mastery of Hebrew was inversely correlated to younger age, more time in the country and higher income. Patients aged 55+ had a poorer self-reported command of Hebrew. According to Remennick (1995), elderly FSU immigrant patients emphasized that language barriers were their most serious problem in interacting with Israeli medical staff. The inability to express their needs and misunderstandings on the part of physicians were reported as reasons for cancelling or postponing medical visits.

31% of FSU immigrant patients needed and used translators during language non-concordant encounters. Like their AI counterparts, most also preferred family members as translators over medical staff or others. AI and FSU immigrant patients interviewed in-depth related language barriers to most other aspects of the encounter, including receiving less medical information, impaired understanding of physicians' explanations and instructions, fewer questions asked, reduced participation in DM, need for more time which was not made available, lower evaluation of physicians' interpersonal communication and friendliness, and feelings of frustration and stress. Language-concordant physicians, usually their family physicians, were reported to meet patients' needs to a much greater extent and were considered to have become their "friends". These results are consistent with reports from the US concerning Spanish-speaking Hispanic-American patients for whom a language barrier existed (Seijo 1991, David 1998, Perez-Stable 1997, 2000).

All patients highly valued information given by the physician and understanding explanations. However, AI and FSU immigrant patients emphasized that language barrier was a major reason for limited information-giving, question asking, and understanding of medical information, which negatively influenced their evaluation of language non-concordant physicians' conduct. These findings are supported by research evidence that provision of information by doctors is positively related to patient satisfaction (Freemon 1971, Cornstock 1982, Roter 1989, Williams 1991b).

All patients interviewed in-depth, regardless of their culture, made similar reports concerning physicians' use of medical terminology that patients failed to understand. Most of the patients reporting such experiences felt uncomfortable asking for clarifications because they were

either embarrassed to let physicians know they failed to understand, or hesitant to take more of the physicians' time. Other patients felt angry, claiming physicians are obliged to clarify information, or anxious that physicians were hiding relevant but worrisome information. These reports match Berlin Ray's (1990) identification of physicians' behaviours that may lead to satisfaction or dissatisfaction.

6.4.5 Time

JI and FSU immigrant patients who use M-time were expected to separate task-oriented time from socio-emotional time in the medical encounter and hence to more easily accept the medical establishment's regulations and monitoring of time. AI patients as members of a collectivistic culture using P-time were expected to be less attuned to time as dictated by the medical establishment to determine relations, schedules and procedures, and to have more flexible attitudes toward time schedules. Due to their people orientation, they were expected to desire human relations with their physician and to integrate task needs with socio-emotional needs.

Israeli physicians, regardless of their culture, are believed to adhere to the time characteristics of Western medicine. In the Western world, M-time is a widespread feature of almost all medical institutions, which adhere to rigid visiting hours and appointment times. Patients using P-time may see such rigid scheduling as inhuman and impersonal (Helman 2001, Purtilo 2002). The traditional authoritarian, doctor-centred approach allows the doctor to control the use of time during the encounter. This clinically-oriented, quick style of consulting is the opposite of the patient-centred approach, which is less structured, more time-consuming and more emotion-seeking (Tate 1983).

JI patients who saw culture-incongruent physicians reported fewer problems of lack of time with AI physicians than with Russian-Israeli physicians. Similarly, AI patients who were treated by both JI and AI physicians reported fewer problems of lack of time than those seen by Russian-Israeli physicians. These findings may suggest that JI and AI physicians complied with JI and AI patients' time needs more than their Russian-Israeli colleagues. The reasons for these findings, already considered in the discussion of the first hypothesis, are presented in brief.

JI and AI physicians seemed to behave in accordance with current modernization trends in the Israeli medical system. They appeared to accommodate JI patients' desire for patient-centred, consumerist approaches by promoting individual goals and needs in a time frame acceptable to patients. Contrary to Russian-Israeli physicians, JI and AI physicians may be more aware

of AI patients' attitudes toward time, including the use of P-time, the desire for more time to befriend the physician, and the use of an elaborate, indirect verbal style. JI and AI physicians, more than Russian-Israeli physicians, seemed able to meet the unique and different needs of JI and AI patients, and to devote suitable time to each group of patients. JI physicians, though members of an individualistic culture following M-time who adhere to schedules and regulations of Israeli Western medicine, seemed to meet AI patients' needs just as well as AI physicians, who are probably more familiar with AI patients' unique time orientation.

Russian-Israeli physicians, on the other hand, may still adhere to a more authoritarian and paternalistic approach that leaves little room for free exchange of information and offers little choice to patients (Brod 1992, Remennick 1998). This approach may minimize interpersonal communication, shorten time offered to patients, and be especially problematic to AI patients. In addition, AI patients' elaborate, affective and indirect verbal style that may be more time consuming, may not have been well understood by Russian-Israeli physicians.

FSU immigrant patients were found to suffer from lack of time more than JI patients, with no significant differences found for physician culture. As discussed earlier, lack of time and language barriers were dominant complaints of FSU immigrant patients, and were found to negatively impact their evaluation of all other examined aspects.

Half of the patients interviewed in-depth complained of shortage of time. Most patients, regardless of their culture, felt that physicians usually are short of time. Patients seemed to understand the reasons for this, among them the patients waiting outside the examination rooms and the physician's workload. Pluchman (1978) reported similar patient complaints and explanations regarding shortage of time.

Many patients shared the feeling that lack of time prevented them from receiving sufficient information. They reported they were denied the opportunity to ask all the questions they wanted, stating that physicians did not volunteer to answer additional questions and that patients limited the number of questions asked because they felt physicians were too busy. AI and FSU immigrant patients who suffered from language barriers reported that lack of time added another burden to their limited ability to make themselves understood and to understand instructions and ask questions. As discussed earlier, limited information-giving, question-asking and understanding of information negatively influenced patients' evaluation of communication with culture non-congruent physicians, and were found to be related to patient dissatisfaction. These findings are supported by evidence linking patient satisfaction to longer visits. Visits during which the physician took the time to chat with the patient yielded a higher level of satisfaction than those with little or no chatting (Gross 1998). In longer

consultations, long-term comorbidity and psychosocial problems as well as the presenting complaint were more likely recognized and addressed, more health education was offered, and patients as well as doctors were more likely to be satisfied (Heaney 2002).

JI patients interviewed in-depth connected shortage of time to receiving insufficient information, while AI and FSU immigrant patients were more concerned that lack of time prevented them from establishing friendly relations with physicians. AI and FSU immigrant patients repeatedly emphasized that language-concordant physicians gave more time for consultation. The extra time was believed to improve the atmosphere of the encounter, facilitate more communication overall and conversations about personal and emotional issues in particular.

6.5 The third hypothesis

The third hypothesis claimed that patients in culture-congruent physician-patient dyads are more likely to report that their needs, expectations and satisfaction were met than are patients in culture-incongruent dyads.

Patients in culture-congruent groups reported increased information-seeking needs, more information-giving by physicians, and an increased willingness on the part of physicians for PDM compared to patients in culture-incongruent groups. Patients in culture-incongruent groups expressed an increased need for PDM when seen by culture-incongruent physicians. Research in this area supports this notion. Patients in the US with race-congruent physicians rated their provider as allowing a more participatory style of DM (Cooper-Patrick 1999).

Patients in culture-congruent groups evaluated physicians' interpersonal communication more positively than patients in culture-incongruent groups, who also expressed more need for improvement in the medical encounter. Patients in the culture-congruent groups were also more satisfied with physicians' medical treatment and courtesy than were patients of culture-incongruent groups. Various studies support these findings. Research in psychology generally indicates that racial paring between patients and therapists results in longer treatment duration and increased patient trust (Sue 1991, Rosenheck 1995). African-American, white, Hispanic, and Asian-American patients who had a choice in selecting their physician were more likely to choose a culture-congruent physician and to report greater satisfaction. African-American patients with culture-congruent physicians were more likely to rate their physicians as excellent as were those with culture-incongruent physicians, and to report receiving preventive and needed medical care. Whites gave white physicians an excellent rating in

listening to patient concerns more often than they so rated non-white physicians (Saha 1999, Laveist 2002).

Patients' reported desires to befriend their physicians (especially AI and FSU immigrant patients) or to have a friendly physician (most patients interviewed in-depth) seem better met by culture-congruent physicians. AI and FSU immigrant patients interviewed in-depth emphasized improved personal relations with culture-congruent, language-concordant physicians. Similarly, mutual friendly relations between culture-congruent physician-patient dyads were reported by van Ryn (2000).

Cultural-congruence/incongruence between providers and patients may affect patient ratings of their care in a number of ways: (1) Negative feelings about a physician from another culture group may affect evaluation of care regardless of actual treatment, as noted with respect to political and economical tensions among the three culture groups in Israel. (2) Members of all cultural groups may have prejudices about people from another culture and who speak with a different accent, as Cummings (1997) reported about the prejudices of whites and African-Americans toward Asian-Americans. In the health care system, both physicians and patients may be prejudiced, and these prejudices have a negative reciprocal effect on their relations. (3) Patients may be uncomfortable with culture-incongruent health providers and respond by not communicating well or by withdrawing, thus negatively affecting interaction quality. (4) Patients who report having a health care provider from their own culture may have specifically sought a culture-congruent physician. Thus, when asked about the quality of the encounter, such patients may avoid cognitive dissonance about their efforts by giving a favourable evaluation. At the same time, however, poor care from a culture-congruent provider may more seriously violate expectations, and be more likely to produce a poor assessment of the physician (Malat 2001).

Language-concordance played a meaningful role in predicting patients' evaluation and satisfaction. AI and FSU immigrant patients seen by culture-incongruent physicians reported more language problems than did patients in culture-congruent pairs. Language barriers were found to negatively affect all patient evaluations. The literature supports the hypothesis that language-concordance affects health care provider ratings. Baker (1996) argued that communication between physicians and patients is difficult even when they have a common language, dialect, and culture. Communication can never be truly satisfactory when the only common linguistic currency between physician and patient consists of a few words or phrases. Language barriers were found to decrease patients' understanding of their disease processes and to negatively impact their compliance with treatment and follow up (Manson

1988, Seijo 1991, Woloshin 1995, Baker 1996, David 1998, Perez-Stable 1997, 2000, Saha 2000).

No statistically significant differences were found between patients in culture-congruent dyads and those in culture-incongruent dyads regarding time, consulting with others, and time to get acquainted with the physician. The findings concerning patient evaluations of time when seen by physicians of the three culture groups were addressed in the discussion of the second hypothesis, and are summarized in brief. Patients interviewed in-depth, regardless of culture, complained of lack of time when seen by most physicians, claiming that all physicians are usually pressed in time. JI and AI patients evaluated the time frame of their visits more positively when seen by JI and AI physicians, which may suggest that these physicians complied with JI and AI patients' time needs better than did their Russian-Israeli colleagues. The desire for more time to get acquainted with physicians was found to be a unique wish of AI patients, who demonstrate collectivist behaviours, use high-context, elaborate verbal styles, and have P-time orientation. This wish seemed to be better understood by AI as well as JI physicians, and not understood by Russian-Israeli physicians.

None of the differences among patients in culture-congruent and incongruent groups were gender dependent. That is, all reported differences were found among male and as well as female patients. Gender was hypothesized as a factor affecting patient preferences for a physician of the same or opposite gender. Female patients were expected to prefer female physicians, and male patients were expected to prefer male physicians, as reported in many studies (Hopkins 1967, Kelly 1980, Challacombe 1983, Fennema 1990, Bensing 1993, Schmittdiel 2000, Ahmad 2002).

The results indicated that over 73% of all patients did not state a preference regarding physician gender. These results contradict studies showing increased patient satisfaction with female physicians (Linn 1984, Bertakis 1995, Bernzweig 1997). A possible explanation for these results has been suggested by Arguette (2000) and Howell (2002), who attributed lack of gender effects to the influence of communication style. Bertakis (1995) reported that patient satisfaction was greater for female than for male physicians, but this gender difference became insignificant when controlled for physicians' practice style. Arguette argued that the use of affiliative communication style (emphasis on development of a positive relationship with patients) rather than gender seems to promote positive patient evaluations. Patients may have positively recalled encounters with both male and female physicians based on physicians' communication style, thus reinforcing their lack of gender preference.

Almost all thirty patients interviewed in-depth thought that male and female physicians do not differ in their professional knowledge and skills. The main reason for preference was a reluctance to be examined physically by a physician of the opposite sex, especially among religious patients. For JI orthodox females and for AI female patients, this preference derives from the laws of modesty, which prohibit being alone with a member of the opposite sex (Silverstein 1995, Madhoc 1992). For female Muslim patients the following order of priorities is suggested: approach a female Muslim physician; if one is not available, a male Muslim doctor, and only if neither is available, a non-Muslim doctor. The latter option is legitimized under the principle of emergency (Rispler-Chaim 1993).

JI and FSU immigrant patients, both males and females, expressed a preference for male physicians. These results were not expected, in light of research evidence suggesting that female physicians exhibit behaviours evaluated by male and female patients alike as more satisfactory than those of male physicians. These behaviours included more total communication, more partnership building, and more positive talk, especially directed at female patients (Linn 1984, Hall 1988, Lieberman 1989, Bertakis 1995, Derose 2001). A possible explanation may be the majority of male physicians in Israeli medical system. Although this trend is slowly changing, JI patients may still be accustomed to male physicians. Another possible explanation may relate to reports that patients with an overall male physician preference rated technical competence as more characteristic of male physicians (Fennema 1990). JI and FSU immigrant patients may emphasize technical competence over emotional responsiveness, thus stressing target-oriented needs in the medical encounter. No statistically significant preference was found for physician gender preference among AI patients, which may be explained by AI patients' overall trust and respect for physicians as discussed earlier.

A high percent of JI and AI female patients felt more comfortable discussing emotional problems with female physicians. This finding parallels reports that female patients are more satisfied with emotional responsiveness and informational partnership provided by female physicians (Roter 1998), and that female patients prefer female physicians based on a feeling that female doctors are generally more sympathetic, particularly about psychological and gynaecological problems (Challacombe 1983, Watson 1999). Fennema (1990) reported that patients tended to describe humane behaviours as characteristic of female physicians, and that the group of patients with an overall preference for female physicians felt this association most strongly. Patients with an overall male physician preference rated technical competence as more characteristic of male physicians.

6.6 Multiple regressions

Similar basic needs among all patients, regardless of culture, were found in the multiple regression correlations for patient age, education level and language barriers.

6.6.1 Age

Older age negatively affected patient desire to participate in DM, evaluation of physician interpersonal communication style, and need for more time. Language problems and the preference to be examined by language-concordant physicians increased with age.

The results concerning the reduced desire for PDM among older patients are in congruence with research evidence. Cassileth (1980) reported that age was the only variable that consistently differentiated between patients who wanted information and active involvement in their own care, and those who preferred a minimum of information and involvement. Younger patients conformed to the well-informed participant approach of patient behaviour, while older patients preferred the older, non-participatory patient role. Age was the most important predictor of preferences regarding desire for information and attitudes regarding keeping, sharing or giving away control to the physician, with older patients preferring less information and control (Degner 1992, Kaplan 1995, Deber 1996, Greenhow 1998). Older patients were less likely to believe in their rights to make decisions or challenge the physician's authority, and more likely to place the locus of authority with the doctor. Younger patients, although giving the physician more authority, were more likely to seek joint decisions (Beisecker 1988). Two explanations may account for older patients' negative attitudes toward involvement in medical DM. (1) Older patients come of age when physicians were traditional power figures, which may lead them to avoid questioning their decisions. (2) As persons age, they may want less responsibility for medical decisions, and tend to rely more on the expertise and responsibility of others.

Results of multiple regressions showed that as patient education level rises, the desire for PDM rises as well. JI patients were more educated than AI patients, which may have added to their increased desire for PDM, along with other reasons such as their individualistic, goal-oriented characteristics. AI patients were younger than the other two culture groups, which may suggest an increased desire for information and PDM. Yet AI patients had other characteristics that seemed to override the impact of age: lower education level than the other two groups, membership in a collectivistic culture, and religious beliefs concerning fatalism and respect for physician's role. All of these factors may account for a decreased desire for PDM regardless of their age. FSU immigrant patients were more educated than either of the

other culture groups, but were older and accustomed to paternalistic Russian health care, which may account for their overall lower desire for PDM.

Older patients' lower satisfaction with physicians' interpersonal communication found in the study is not consistent with a large body of research evidence suggesting that older patients tend to be more satisfied with health care than younger people. Several explanations have been suggested in the literature. The elderly may have lower expectations, make fewer demands, are more easily satisfied and more grateful, and are reluctant to articulate their dissatisfaction due to dependency on the medical staff (Hooper 1982, Gray 1983, Houts 1986, Blanchard 1990, Zahr 1991, Williams 1991a, Owens 1996, Greenhow 1998).

One explanation for the study's results refers to physicians' attitudes and behaviours towards elderly patients, regardless of their culture. Ageism, or prejudice against the elderly, is manifested in the health care environment in a number of ways: older patients receive less attention or are denied services based on their age alone; physical and psychological problems are assumed normal for elderly and may not be addressed by professionals; older patients are often overmedicated and experience the effects of poorly coordinated care; and elderly patients are often met with a patronizing attitude (Purtilo 2002).

Aging is accompanied by a high risk of chronic ailments, some which may have taken root at an earlier time in life. Chronic problems require a different type of medical care, and must be managed through cooperation of physician and patient, with family, on a long-term basis (Loustaunan 1997). Bereavement, financial insecurity, isolation, dependency, inadequate housing, lack of transportation, and other issues cause difficulties for the elderly (Waitzkin 1994). Many older patients consult practitioners who feel the social context is not relevant to the medical task, or that their ability to grapple with contextual problems is limited. When such issues do arise, the structure of discourse tends to cut off and ultimately to marginalize the discussion, even though these concerns may create substantial day-to-day distress (Waitzkin 1993, 1994). All these factors may account for reduced satisfaction of the elderly, regardless of their culture. It may also be particularly true for older FSU immigrant patients, who suffer from more absorption difficulties due to increased language barrier, lower income, and poorer health status as compared to younger immigrants.

Another explanation may refer to cultural differences in status attributed to the elderly. Respect for elders is usually much greater in traditional, rural societies, where the elders are the living repositories of history and ancient traditions; this is more typical of AI culture. Modern western industrial society, with its emphasis on youth, productivity, individualism, and autonomy, is often quite intolerant of old people (Helman 2001), and may be more typical

of JI society. AI older patients as members of a collectivistic culture may have been dissatisfied with the "straightforward" style of JI and Russian-Israeli physicians, interpreted as lack of courtesy and respect for the elderly.

6.6.2 Education

Multiple regressions showed that as patient educational level rises the desire for PDM rises as well, and evaluations of physicians' reported interpersonal communication are less positive. Research evidence supports these findings. Silverman (1987) argued that the power relations in the physician-patient relationship are only really challenged if the impetus for more control over the encounter comes from patient; higher social class or higher education level were identified as possible sources of resistance. PDM facilitation was associated with higher education level by Waitzkin (1996), Gotler (2000), and Adams (2001). These findings may describe the case of FSU immigrant patients, who were better educated than their counterparts. FSU immigrant patients felt their physicians were less willing to engage in PDM than did either JI or AI patients. The less positive evaluation of physician interpersonal communication is consistent with reports that lower levels of education were found to be associated with greater satisfaction, while higher educational attainment was associated with dissatisfaction (Hall 1990a, 1990b, Andersson 1993, Schutz 1994).

6.6.3 Language and time

As patient age rises, reports of language problems increase. AI and FSU immigrant patients suffered from language barriers when visiting language non-concordant physicians. Mastery of Hebrew has been correlated to the age of FSU immigrant (Al-Haj 2000). Younger FSU immigrants reported better Hebrew proficiency in all categories of fluency: oral comprehension, conversational skills, reading, and writing. Older FSU immigrant patients with lesser Hebrew proficiency therefore suffered from more problems deriving from language barriers. Older AI patients may also have a poorer command of Hebrew and suffer from increased language barriers, as compared to younger AI patients who received more schooling.

As patient age and education levels rise, the desire to be treated by physicians who speak the patient's own language increases as well. The preferences of JI patients cannot be attributed to language barriers, and may therefore hint at previously discussed tensions with the AI population, and with their overall lower satisfaction when examined by Russian-Israeli physicians.

The desire of older AI and FSU immigrant patients for language-concordant physicians corresponds with their reduced Hebrew proficiency and increased language barriers. Older AI patients may also feel more at ease with culture-congruent physicians, who may be more familiar with their unique culturally-based health beliefs, needs and behaviours and therefore treat them more respectfully. Similarly, older FSU immigrant patients who have more absorption problems than younger immigrants may wish to be seen by Russian-speaking physicians, who may empathize with their problems more than JI and AI physicians.

The preference of more educated AI patients for language-concordant physicians cannot be explained by their Hebrew proficiency, which is probably relatively good. It may be related to underlying political tensions among the three culture groups, which may also explain the preferences of JI patients and FSU immigrant patients. In addition, this preference may also reflect findings showing that a higher education level increases the problem of lack of time. AI patients reported receiving more time from JI and AI physicians than from Russian-Israeli physicians. This time issue may be more crucial to more educated AI as well as JI patients, who may want more information-giving from physicians and a better understanding of information and instructions, both of which may require extra time.

The need for more time during the medical encounter was found to drop among older patients. Research evidence supports this result. Keeler (1982), Beisecker (1990), and Kaplan (1996) reported that more time with patients might be required to present and discuss treatment options and arrive at mutually acceptable treatment plans. However, older patients were found to take less time and to prefer less information, less control and less participation in DM (Degner 1992, Kaplan 1995, Deber 1996, Greenhow 1998).

6.7 Limitations of study

No study on such a wide topic can achieve universal coverage of the subject, and this study is no exception. The following limitations to the data and results should be noted.

The three culture groups examined are comprised of sub-groups that were not addressed in this study. Jewish-Israeli physicians and patients include individuals from Ashkenazi and Sephardic origin, those who were born in Israel, and those who immigrated from a large number of Diaspora countries. Arab-Israeli physicians and patients comprise individuals practicing several religions, including Muslim, Christian, and Druze. FSU physicians and patients immigrated to Israel from the various states of the former Soviet Union, which are marked by culturally-based differences. For the purposes of the current study, it was assumed

that even a broad definition of the three culture groups would provide valuable information, especially in view of the limited research evidence from the Israeli health care system.

The ethical considerations of the Helsinki Ethical Committee of the Bnai-Zion Medical Centre regarding respect for patient privacy and anonymity prevented the researcher from using additional evaluation tools, such as observing or videotaping the encounters. Therefore, the non-verbal communication and individual behaviour characteristics of physicians and patients, found in the literature to affect relations, could not be assessed. Due to the same ethical considerations, access was not permitted to patient medical records. Thus, the study did not include assessment of patient health status, shown by research evidence to influence patient needs, expectations and satisfaction.

The study is limited by the absence of participating female Arab-Israeli physicians, and by the smaller number of Arab-Israeli and Russian-Israeli physicians compared to the number of Jewish-Israeli physicians.

Data was collected in a single hospital in Haifa. Nevertheless, the patient cohort of the Bnai-Zion Medical Centre is comprised of the population of city of Haifa, as well as its suburbs and rural villages and kibbutzim of the northern part of Israel. It is therefore believed to represent the main characteristics of the Israeli patient cohort.

6.8 Recommendations for further research

Further research is recommended to explore and compare dimensions of cultural variability within the cultural sub-groups of the three culture groups that have been addressed in this study, and in the interactions between physicians and patients from all of these groups. Moreover, further research is recommended that will include the assessment of patient health status, and socio-economic status, which were unavailable for the current study. It is also recommended to further explore patients' attitudes, expectations, needs and satisfaction in other geographic regions of Israel, which may have a different population mix.

The ethical considerations demanded by the Bnai Zion Medical Centre's Helsinki ethical committee with regard to respect for patient privacy and anonymity prevented the researcher from using additional evaluation tools, such as observations or videotaping of the encounters, which are recommended for future research.

The current study did not refer to physician assessment of dealing with patients from the three culture groups. Further research may compare differences between the views and evaluations of physicians and those of patients. Such a comparison could improve physicians' self-

assessment, and increase their awareness of the discrepancies between their own evaluation and reports by their patients.

6.9 Recommendations for administrators and medical educators

The practical implications of the study's results can impact a variety of public and organizational bodies, including administrators and decision-makers in governmental and health care organizations, medical school educators, and health care practitioners and staff members who treat patients from different cultures every day.

Patient experiences are potentially shaped by the health care context as well as by interactions and prejudices from their daily life. Widespread changes in the nature of cultural and political beliefs embedded in the governmental system and the health care system, as manifested in the organization of life for AI minority patients and Jewish immigrant patients, are required to achieve real improvements in the experiences of these patients. These changes are expected to develop over a long period of time. In the meantime some more specific recommendations are suggested.

The importance of culturally-congruent physicians in improving patient healthcare experiences has implications for enrolment in medical education. Potential culture-based affirmative action strategies should be encouraged in educating minority physicians, especially among the AI and Ethiopian immigrants' population.

Despite the multitude of cultures in Israel, physicians seem to be inadequately trained to meet the complexities of providing care to culturally diverse patients. Better training of medical students and physicians could reduce cultural tension. The skills learned through intercultural training could help promote communication, negotiation and cooperation, improve clinical diagnosis and management, avoid cultural blind spots and unnecessary medical testing, and improve physician-patient understanding and relations. Medical school curricula and continuing medical education programs should be examined and improved to provide the training needed to practice medicine in Israel's multicultural, multilingual society.

Communication is a skill often taken for granted. Yet, because it is overshadowed by the explosion of knowledge in diagnostic and therapeutic medical disciplines, the approach toward the patient is often regarded with little importance. Communication, however, remains a most important tool for the medical profession. New technologies cannot replace the need for a caring, compassionate and understanding physician. Medical school curricula and continuing medical education programs should provide the training needed to improve

physicians' communication skills in order to enhance effective communication between physicians and patients.

When interviewed for medical schools, student candidates should be singled out not only according to scholastic considerations, but also based on personality qualifications. Nowadays, interviews usually single out academic excellence and seem to ignore the need to find students who will become humane physicians, attuned to patient distress.

Language barriers were found to impair effective communication and to cause frustrations, misunderstandings, and dissatisfaction. Including trained interpreters in medical facilities would create links between health services and minority and immigrant communities, help identify the problems affecting the health and health care of these population groups, and improve communication during encounters.

Use of professional translation services (face-to-face and remote) by clinics and hospitals is recommended to overcome problems deriving from language barriers. Since providing such services is costly and cannot be afforded by all medical services, a potential solution is to train volunteers from minority and immigrant communities. Another option is to establish voluntary services by associations such as the Israel Translators Association. Where these services are unavailable, bilingual and bicultural staff members can be trained as linguistically and culturally competent translators.

The ultra-technological era in health care emphasizing the use of new technologies and advanced testing techniques was found to impair relations between physicians and patients and create feelings of alienation. Along with providing patients with tests results, physicians must allocate time and attention for talking, listening, and building relations in order to avoid estrangement.

The increased use of modern technology and testing and the use of computers in office visits take up much of physicians' time and attention during the encounter, and reduce face-to-face contact. Longer consultation times are required to combine technical necessities with personal attention and effective communication.

Minority and immigrant patients expressed the need and desire for longer consultations with physicians, particularly due to language barriers and difficulties in understanding and making themselves understood. Even though physicians are highly pressured for time, clinics would do well to consider scheduling appointments for such patients at longer intervals.

Chapter 7 Concluding remarks

Vast research evidence suggests that culture has a substantial impact on the success and outcomes of the medical encounter. The current study found support for this notion by examining physician-patient relations in three culturally diverse groups in Israel. Differences between patients' attitudes, needs, and behaviours were found in all examined aspects of the medical encounter, and among all the three groups, in the interaction of culture-congruent and culture-incongruent physician-patient dyads.

It should, however, be noted that although of great importance, culture is but one variable that has been reported to affect relations. Other physician and patient characteristics, such as socio-economic status, age, education level, health status, and gender, have also been found to influence the attitudes and behaviours of both partners to the medical encounter.

Issues of health and illness are surrounded by conflict and emotion. How the medical community understands these issues is interlinked with the socio-cultural settings in which they are experienced. Medical training engenders a set of beliefs and a system of knowledge that determine how physicians diagnose illness and respond to patients. This knowledge is based upon the scientific-biomedical method of accumulating "facts", with little room devoted to consideration of human communication. While patients look to medicine to provide help when they are ill, they also express frustration at the feeling of powerlessness and disappointment they sometimes experience in the medical encounter.

The introduction of cultural concepts into the education of health care professionals aims to make health care providers more culturally competent. This implies that within the delivery of care, the health care provider attends to the total context of the patient, examining health care issues and perceptions from a broad cultural viewpoint. By understanding that the socio-cultural bases of health care, illness conditions and beliefs are subject to change and negotiation, physicians and patients may avoid taken-for-granted assumptions and stereotyping.

Two aspects that deserve special attention are problems deriving from language barriers, and from time allocation. Language barriers present a critical threat to communication between language-noncorcordant health care providers and patients. Problems deriving from language barriers can bring communication to a halt, and lead to misunderstandings, frustration and conflict. Training interpreters to serve as "culture brokers"- who convey patients' responses, and help in assessing their reality, experience, and world view- may reduce the chances of misunderstanding and conflict between physicians and patients.

The management of time is of utmost importance for medical staff, who deal with many patients in a limited period of time. The situation often demands that physicians limit the extent of personal interaction in favour of professional obligations, which leads to patients being treated as "cases", despite the needs of many patients to be treated as an individual person. Allocation of more time to listening to patients' stories and concerns and to providing requested information, may serve to improve the atmosphere of the encounter, as well as enhance patients' understanding, satisfaction, and medical outcomes.

The purpose of this study has been to raise Israeli physicians' awareness of the various dimensions and complexities involved in caring for people from diverse cultural backgrounds. The characteristics and differences that have been found and discussed cannot account for the richness of any one culture or health belief system. However, they are believed to inform and sensitize health care professionals to the need to elicit the narratives of people within their cultural context, and to seek to uncover the voice of the individual patient.

Every culture defines what health and illness are for its members. Nevertheless, one must bear in mind that variations may occur within subgroups as well as from one individual to another. Each patient is unique, and develops his or her own interpretations of cultural guidelines. A culturally informed, patient-centred encounter, in which an understanding of the patient's needs, attitudes and beliefs is sought and respected, may reduce cultural misunderstandings. Moreover, respect for the patient's culture must be accompanied by parallel respect for the particular patient's experience and needs; otherwise, cultural knowledge becomes a mere list of stereotypical beliefs and values.

Listening to each patient, while recognizing the multiple cultural contexts involved- those of the patient, of the physician, and of medicine itself- is believed to enable health care providers to negotiate among potential differences, in order to reach mutually desired goals for care, and to accommodate the treatment that best serves the interests of the individual patient.

Chapter 8 References

Adams, P., Mylander, M. (1998). Gesundheit! Rochesrer, VT: Healing Arts Press.

Adams, R.J., Smith, B.J., Ruffin, R.E. (2001). Impact of the physician's participatory style in asthma outcomes and patient satisfaction. Ann Allergy Asthma Immunol: 86; 263-271.

Ahmad, F., Gupta, H., Rawlins, J., Stewart, D. (2002). Preferences for gender of family physician among Canadian European-descent and South-Asian immigrant women. Fam Pract: 19; 146-153.

Al-Haj, M. (1989). Social research on family lifestyles among Arabs in Israel. J Comparative Fam Studies: 20; 175-193.

Al-Haj, M. (1991). The attitudes of the Palestinian Arab citizens in Israel towards Soviet Jewish immigration. Intl J Refugee Law: 3; 243-263.

Al-Haj, M. (1993). Ethnicity and immigration: the case of Soviet immigration to Israel. Humboldt J Soc Relations: 19; 279-305.

Al-Haj, M., Leshem, E. (2000). Immigrants from the former Soviet Union in Israel: ten years later. University of Haifa.

Ali, N.S., Khalil, H.Z., Yousef, W. (1993). A comparison of American and Egyptian cancer patients' attitudes and unmet needs. Cancer Nursing: 16; 193-203.

Almaney, A. Alwan, A. (1982). Communicating with the Arabs. Prospect Heights, IL: Waveland Press, Inc.

Andersson, L.A., Zimmerman, M.A. (1993). Patient and physician perceptions of their relationship and patient satisfaction: a study of chronic disease management. Patient Educ Couns: 20; 27-36.

Annandale, E., Hunt, K. (1998). Accounts of disagreement with doctors. Soc Sci Med: 46; 119-129.

Antonovsky, A. (1979). Health, stress and coping. San Francisco, CA: Jossey-Bass.

Argyle, M., Furnham, A., Graham, J. (1981). Social situations. Cambridge: Cambridge University Press.

Aruguete, M.S., and Roberts, C.A. (2000). Gender, affiliation, and control in physician-patient encounters. Sex Roles: 42; 107-118.

Ashton, C.M., Haidet, P., Paterniti, D.A., Collins, T.C., Gordon, H.S., O'Malley, K., Peterson, L.A., Sharf, B., Suarez-Almazor, M.E., Wray, N.P., Street, R.L. Jr. (2003). Racial and ethnic disparities in the use of health services. Bias, preference, or poor communication? J Gen Intern Med: 18; 146-152.

Baider, l., Ever-Hadani, P., Kaplan De-Nour, A. (1995). The impact of culture on perceptions of patient-physician satisfaction. Isr J Med Sci; 31: 179-185.

Baider, L., Uzieli, B., Kaplan De-nour, A. (1997). The impact of perceived behavior on patient-physician satisfaction. Annals of NY Acad Sci; 809: 266-278.

Bain, D.J.G. (1979). The relationship between time and clinical management in family practice. Fam Pract: 8; 351-359.

Baker, D.W., Hayes, R., Fortier, J. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. Med care: 36; 1461-1470.

Baker, D.W., Parker, R.M., Williams, M.V., Coates, W.C., Pitkin, K. (1996). Use and effectiveness of interpreters in an Emergency Department. JAMA: 275; 783-788.

Baker, R. (1991). The reliability and criterion validity of a measure of patients' satisfaction with general practice. Fam Pract: 8; 171-177.

Ballard-Reisch, D. (1990). A model of participative decision making for physician-patient interaction. Health Communication: 2; 91-104.

Ballard-Reisch, D. (1993). Health care providers and consumers. Making decisions together. In B.C. Thornton, and G.L. Kreps (eds). Perspectives on health communication (pp. 66-80). Prospect Heights, IL: Waveland Press, Inc.

Barker, J.C. (1992). Cultural diversity- changing the context of medical practice. Western J Med: 157; 248-255.

Barlund, D. (1976). The mystification of meaning: Doctor-patient encounters. J Med Educ: 51; 716-725.

Barlund, D.C. (1993). The mystification of meaning: Doctor-patient encounters. In B.c. Thornton, and G.L. Kreps. Perspectives on health communication (pp. 30-41). Prospect Heights, Ill: Waveland Press, Inc.

Barr, D.A. (1996). The ethics of Soviet medical practice: behaviours and attitudes of physicians in Soviet Estonia. Med Etics: 22; 33-40.

Barry, C.A., Stevenson, F.A., Britten, N., Barber, N., Bradley, C.P. (2001). Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. Soc Sci Med: 53; 487-505.

Barsky, A.J. (1981). Hidden reasons some patients visit doctors. Ann Intern Med: 94; 492-498.

Bates, B., Bickley, L.S., Hoekelman, R.A. (1995). Physical examination and history taking. Philadelphia, PA: J.B. Lippincott Company.

Beach, W., Dixon, C. (2001). Revealing moments: formulating understanding of adverse experiences in a health appraisal interview. Soc Sci Med: 52; 25-44.

Beck, U., Giddens, A., Lash, S. (eds) (1994). A reflexive modernization: politics, tradition and aesthetics in modern social order. Cambridge: Polity Press.

Becker, M.H. (1974). The health belief model and sick role behaviour. Health Education Monograph: 2; 409-419.

Becker, M.H., Maiman, L.A. (1975). Socibehavioral determinants of compliance with health and medical care recommendations. Med Care: 13; 10-24.

Beckman, H., Markakis, K., Suchman, A., Frankel, R. (1994). Getting the most from a 20-minute visit. Am J Gastro: 89; 662-664.

Beckman, H.B., Frankel, R.M. (1984). The effect of physician behavior on collection of data. Annals of Internal Medicine: 101; 692-696.

Beckman, H.B., Frankel, R.M., Darnley, J. (1985). Soliciting the patient's complete agenda. A relationship to the distribution of concerns. Clinical Research: 31; 714A.

Beisecker, A.E. (1988). Aging and the desire for information and input in medical decisions: patient consumerism in medical encounters. Gerontologist: 28; 330-335.

Beisecker, A.E., Beisecker, T.D. (1990). Patient Information-seeking behaviors when communicating with doctors. Med Care; 28: 19-28.

Bell, R.A., Kravitz, R.L., Thom, D., Krupat, E., Azari, R. (2001). Unsaid but not forgotten. Patients' unvoiced desires in office visits. Arc Intern Med: 161; 1977-1984.

Bellet, P.S., Maloney, M.J. (1991). The importance of empathy as an interviewing skill in medicine. JAMA: 266; 1831-1832.

Bem, S. (1974). The measurement of psychological androgyny. J Consulting and Clinic Psychology: 42; 155-162.

Ben-Rafael, E. (1982). The emergence of ethnicity. Cultural groups and social conflict in Israel. Contributions in Ethnic Studies, Number 7. Westport, CT: Greenwood Press.

Bensing, J.M., van den Brink-Muinen, A., de Bakker, D.H. (1993). Gender Differences in practice style: a Dutch study of general practitioners. Med Care: 31; 219-229.

Ben-Sira, Z. (1976). The function of the professional's affective behaviour in client satisfaction: a revised approach to social interaction theory. JR Health and Soc behav: 17: 3-11.

Ben-Sira, Z. (1980). Affective and instrumental components in the physician-patient relationship: an additional dimension of interaction theory. J Health Soc Behav: 21; 170-180.

Berglund, C.A. (2001). Health research. South Melbourne, Victoria: Oxford University Press.

Berlin Ray, E., Donohew, L. (1990). Communication and health: Systems and applications. Hillsdale, NJ: Lawrence Erlbaum Ass. Pub.

Bernstein J.H., Shuval, J.T. (1994). Emigrant physicians evaluate the health care system of the Former Soviet Union. Med Care: 32; 141-149.

Bernstein, B., Kane, R. (1981). Physicians' attitudes toward female patients. Med Care: 19; 600-608.

Bernzweig, J., Takayama, J.I., Phibbs, C., Lewis, C., Pantell, R.H. (1997). Gender differences in physician-patient communication. Arch Pediatr Adolesc Med: 151; 586-591.

Berris, J.C. (1988). The art of interpreting. In L.A. Samovar, and R.E. Porter (eds). Intercultural communication: A reader (pp. 262-269). Belmont,CA: Wadsworth, Inc.

Bertakis, K.D., Helms, L.J., Callahan, E.J., Azari, R., Robbins, J.A. (1995). The influence of gender on physician practice style, Med care: 33; 407-416.

Bertakis, K.D., Roter, D., Putman, S.M. (1991). The relationship of physician medical interview style to patient satisfaction. J Fam Prac: 32; 175-181.

Bickley,V.C. (1988). Language as the bridge. In L.A. Samovar, and R.E. Porter (eds). Intercultural communication: A reader (pp. 233-243). Belmont, CA: Wadsworth, Inc.

Biderman, A., Carmel, S., Yeheskel, A. (1994). Measuring patient satisfaction in primary care: a joint project of community perspectives, clinic staff members and a social scientist. Fam Pract: 11; 287-291.

Billings, J.A., Stoeckle, J.D. (1989). The clinical encounter. A guide to the medical interview and case presentation. Chicago: Year book Medical Publishers, Inc.

Bilu, Y., Witztum, E. (1992). Working with Jewish ultra-orthodox patients: guidelines for a culturally sensitive therapy. Culture, Med Psych: 17; 1-37.

Bilu, Y., Witztum, E. (1994). Culturally sensitive therapy with ultra-orthodox patients: the strategic employment of religious idioms of distress. Israel J Psych and related Sci: 31; 170-182.

Blackhall, L.J., Murphy, S.T., Frank, G., Michel, V., Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. JAMA: 274; 820-825.

Blanchard, E.B., Labrecque, M.S., Ruckdeschel, J.C., Blanchard, E.B. (1990). Physician behaviours, patient perceptions, and patient characteristics as predictors of satisfaction of hospitalized adult cancer patients. Cancer: 65; 186-192.

Bolton, R. (1986). People skills. New York: Simon & Schuster.

Borges, S., Waitzkin, H. (1995). Women's narratives in primary care medical encounters. Women and Health: 23; 29-56.

Bowling, A. (1999). Research methods in health: Investigating health and health services. Buckingham: Open University Press.

Braboy Jackson, P., George, L.K. (1998). Racial differences in satisfaction with physicians. A study of older adults. Research on aging: 20; 298-316.

Branch, W.T., Malik, T.K. (1993). Using "windows of opportunities" in brief interviews to understand patients' concerns. JAMA: 269; 1667-1668.

Brital, D. (1990). The Soviet Jews. Jerusalem: The Hebrew University of Jerusalem. (Hebrew).

Britt, H., Bhasale, A., Miles, D.A., Meza, A., Sayer, G.P., Angelis, M. (1996). The sex of the general practitioner: A comparison of characteristics, patients, and medical conditions managed. Med Care: 34; 403-415.

Britten N. (2001). Prescribing and the defense of clinical autonomy. Soc Health Illness: 23; 478-496.

Britten, N., Stevenson, F.A., Barry, C.A., Barber, N., Bradley, C.P. (2000). Misunderstandings in prescribing decisions in general practice: qualitative study. BMJ: 320; 484-488.

Brock, D.W., Wartman, S.A. (1990). When competent patients make irrational choices. New England J Med: 322; 1595-1599.

Brod, M., Heurtin-Roberts, S. (1992). Older Russian emigres and medical care. West J Med: 157; 333-337.

Brody, D.S. (1980). The patient's role in clinical decision-making. Annals Intern Med: 93; 718-722.

Brody, D.S., Miller, S.M., Lerman, C.E., Smith, D.G., Lazaro, M.S., Blum, B.A. (1989). The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. Med Care; 27: 1027-1035.

Brown, J., Stewart, M., Tessier, S. (1995). Assessing communication between patients and doctors: a manual for scoring patient-centered communication. London: Thames Valley Family practice Research Unit.

Brown, J.B., Stewart, M., McWilliam, C.L. (1999). Using the patient-centered method to achieve excellence in care for women with breast cancer. Patient Educ Counc: 38; 121-129.

Bruera, E., Sweeney, C., Calder, K., Palmer, L., Benisch-Tolley, S. (2001). Patient preferences versus physician perceptions of treatment decisions in cancer patients. J clin Oncl: 19; 2883-2885.

Buller, M.K., Buller, D.B. (1987). Physicians' communication style and patient satisfaction. J Health Soc Behav: 28; 375-388.

Butow, P.N., Tattersall, M.H., Goldstein, D. (1997). Communication with cancer patients in culturally diverse societies. Annals New York Acad Sci: 809; 317-329.

Byrne, P.S., Long, B.E.L. (1976). Physicians talking to patients: a study of the verbal behaviour of general practitioners in their surgeries. London: Her Majesty's Stationery Office.

Cahill, J. (1996). Patient participation: a concept analysis. J Advanced Nursing: 24; 561-571.

Callahan, E.J., Bertakis, K.D. (1991). Development and validation of the Davis Observation Code. Fam Med: 23; 19-

Camasso, M.J., Camasso, A.E. (1994). Practitioner productivity and the product content of medical care in publicly supported health centers. Soc Sci Med: 38; 733-748.

Carlisle, D.M., Gardner, J.E., Honghu, L. (1998). The entry of underrepresented minority students into US medical schools: an evaluation of recent trends. Am J Pub Health: 88; 1314-1318.

Carmel, S., Glick, S.M. (1996). Compassionate-empathic physicians: personality traits and social-organizational factors that enhance or inhibit this behaviour pattern. Soc Sci Med: 43; 1253-1261.

Carrasquillo, O., Orav, E.J., Brennan, T.A., Burstin, H.R. (1999). Impact of language barriers on patient satisfaction in an emergency department. J Gen Inter Med: 14; 82-87.

Carrillo, J.E., Green, A.R., Betancourt, J.R. (1999). Cross-cultural primary care: a patient-based approach. Ann Intern Med: 130; 829-834.

Carter, W.B., Inui, T.S., Kukull, W., Haigh, V.H. (1982). Outcome-based doctor-patient interaction analysis II: identifying effective provider and patient behaviour. Med Care: 20; 550-566.

Cassell, E.J. (1985). Talking with patients.Volume 2: Clinical technique. Cambridge, Ma: MIT Press.

Cassell, F.J. (1976). The healer's art: a new approach to the doctor-patient relationship. New York: Lippincott.

Cassileth, B.R., Vlassov, V.V., Chapman, C.C. (1995). Health care, medical practice, and medical ethics in Russia today. JAMA: 273; 1569-1573.

Cassileth, B.R., Zupkis, R.V., Sutton-Smith, K., March, V. (1980). Information and participation preferences among cancer patients. Annals of Intern Med: 92; 832-836.

Cegala, D.J., McClure, L., Marinelli, T.M., Post, D.M. (2000). The effect of Communication skills training on patients' participation during medical interview. Patient Educ Couns: 41; 209-222.

Chae, M. (1987). Older Asians. J Gerontol Nurs: 13; 10-17.

Challacombe, C.B. (1983). Do women patients need women doctors? The Practitioner: 227; 848-950.

Chan, D., Gan Goh, L. (2000). The doctor-patient relationship: a survey of attitudes and practices of doctors in Singapore. Bioethics: 14; 58-76.

Charles, C., Gafni, A., Whelan, T. (1997). Shared decision-making in the medical encounter: what does it mean? (Or, it takes at least two to tango). Soc Sci Med: 44; 681-692.

Charles, C., Gafni, A., Whelan, T. (1999). Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. Soc Sci Med: 49; 651-666.

Charles, C., Whelan, T. Gafni, A., Willan, A, Farrell, S. (2003). Shared treatment decision making: what does it mean to physicians? J Clin Oncol: 21; 932-936.

Cleary, P.D. (1998). Satisfaction may not suffice! Int J Technol Assess Health Care: 14; 35-37.

Cleary, P.D., McNeil, J. (1988). Patient satisfaction as indicator of quality care. Inquiry: 25; 25-36.

Cohen, R. (1987). Problems of intercultural communication in Egyptian-American diplomatic relations. International J Intercultural Relations: 11; 29-47.

Cohen, S., Moran-Ellis, J. Smaje, C. (1999). Children as informal interpreters in GP consultations: pragmatics and ideology. Soc Health and Illness: 21(2); 163-186.

Colameco, S., Becker, L.A., Simpson, M. (1983). Sex bias in the assessment of patient complaints. J Fam Pract: 16; 1117-1121.

Collins, T.C., Clark, J.A., Petersen, L.A., Kressin, N.R. (2002). Racial differences in how patients perceive physician communication regarding cardiac testing. Med Care: 40 (supp); I-27-I-34.

Comstock, L.M., Hooper, E.M, Goodwin, J.M., Goodwin, J.S. (1982). Physician behaviours that correlate with patient satisfaction. J Med Educ: 57; 105-112.

Cooper-Patrick, L., Gallo, J.J., Gonzales, J.J., Vu, H.T., Powe, N.R., Nelson, C., Ford, D.E. (1999). Race, Gender, and Partnership in the patient-physician relationship. JAMA; 282: 583-589.

Cornstock, L.M., Hooper, E.M., Goodwin, J.M., Goodwin, J.S. (1982). Physician behaviours that correlate with patient satisfaction. J Med Educ: 57; 105-112.

Coulter, A. (1999). Paternalism or partnership? Patients have grown up and there's no going back. Br Med J: 319; 719-720.

Crawford, A. (1999). "We can't all understand the whites' language": An analysis of monolingual health services in a multilingual society. Int'l J Soc Lang: 136; 27-45.

Cromarty, J. (1996). What do patients think about during their consultations? A qualitative study. Br J Gen Pract: 46; 525-528.

Cummings, S., Lambert, T. (1997). Anti-Hispanic and anti-Asian sentiments among African Americans. Soc Sci Quarterly: 78; 338-353.

Cushner, K., Brislin, R.W. (1996). Intercultural interactions. A practical guide. Thousand Oaks, CA: Sage Pub, Inc.

Daly, M.B., Hulka, B.S. (1975). Talking with the Doctor. Journal of communication: 25; 148-152.

Daniel, A.E., Burn, R.J., Horarik, S. (1999). Patients' complaints about medical practice. MJA: 170; 598-602.

David, R.A., Rhee, M. (1998). The impact of language as a barrier to effective health care in an underserved urban Hispanic community. The Mount Sinai J Med: 65; 393-397.

Davidoff, F. (1997). Time. Ann Intern Med: 127; 483-485.

Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. J Sociolinguistics: 4/3; 379-405.

Davidson, B. (Oct 2001). Questions in cross-linguistic medical encounters: The role of the hospital interpreter. Anthropological Quarterly: 74 (4); 170-178.

Davies, A.R., Ware, J.E. (1991). GHAA's consumer satisfaction survey and user's manual. Washington, DC: Group Health association of America.

Deber, R.B. (1994). Physicians in health care management: The patient-physician partnership: decision making, problem solving and the desire to participate. Can Med Assoc J: 151; 423-427.

Deber, R.B., Kraetschmer, N., Irvine, J. (1996). What role do patients wish to play in treatment decision making? Arch Intern Med: 156; 1414-1420.

DeCoster, V.A. (1997). Physician treatment of patient emotions: an application of the sociology of emotion. Social Perspectives on Emotion: 4; 151-177.

Degner, L.F., Kristjanson, L.J., Bowman, D., Sloan, J.A., Carriere, K.C., O'Neil, J. Bilodeau, B., Watson, P., Mueller, B. (1997). Information needs and decisional preferences in women with breast cancer. JAMA: 277; 1485-1492.

Degner, L.F., Sloan, J.A. (1992). Decision making during serious illness: What role do patients really want to play? J Clin Epidemiol: 45; 941-950.

DeMonchy, C., Richardson, R., Brown, R., Harden, R. (1998). Measuring attitudes of doctors: the doctor patient rating. Med Educ: 22; 231-239.

Derose, K.P., Hays, R.D., McCaffrey, D.F., Baker, D.W. (2001). Does physician gender affect satisfaction of men and women visiting the emergency department? J Gen Intern Med: 16; 218-226.

Deveugele, M., Derese, A., De Maeseneer, J. (2002). Is GP-patient communication related to their perceptions of illness severity, coping and social support/ Soc Sci Med: 55; 1245-1253.

Di Blasi, Z., Harkness, E., Ernst, E., Georgiou, A., Kleijnen, J. (2001). Influence of context effects on health outcomes: a systematic review. Lancet: 357; 757-762.

DiMatteo, M.R., DiNicola, D.D. (1982). Achieving patient compliance. The psychology of the medical practitioner's role. New York: Pergamon Press.

DiMatteo, M.R., Hays, R. (1980). The significance of patients' perceptions of physician conduct: a study of patient satisfaction in a family practice center. J Community Health: 6; 18-34.

DiMatteo, M.R., Prince, L.M., Taranta, A. (1979). Patients' perceptions of physician behaviour: determinants of patient commitment to the therapeutic relationship. J Community Health: 4; 280-290.

Donabedian, A. (1980). Explorations in quality assessment and monitoring. Vol. 1: The definition of quality and approaches to its assessment. Ann Arbor, MI: Health Administration Press.

Donin, H.H. (1972). To be a Jew. New York: Basic Books.

Druss, B., Mechanic, D. (2003). Should visit length be used as a quality indicator in primary care? Lancet: 361; 1148.

Dugdale, D.C., Epstein, R., Pantilat, S.Z. (1999). Time and the patient-physician relationship. JGIM: 14 (Supp.1); S34-S40.

Dwyer, J. (Mar/Apr 2001). Babel, Justice, and Democracy: Reflections on shortage of interpreters at a public hospital. The Hastings Center Report: 31; 31-36.

Ebden, P., Bhatt, A., Carey, O.J. and Harrison, B. (1988). The bi-lingual consultation. Lancet: 8581i; 347.

Eddy, D.M. (1990). Anatomy of a decision. JAMA: 263; 441-443.

Ehman, J.W., Ott, B.B., Short, T.H., Ciampa, R.C., and Hansen-Flaschen, J. (1999). Do patients want physicians to inquire about their spiritual or religious beliefs if they become gravely ill? Arch Intern Med: 159; 1803-1806.

Ehrenreich, J. (1978). Introduction: the cultural crisis of modern medicine. In J Ehrenreich (ed). The cultural crisis of modern medicine (pp. 1-35). New York: Monthly review Press.

Elderkin-Thompson, V., Cohen Silver, R., Waitzkin, H. (2001). When nurses double as interpreters: A study of Spanish-speaking patients in a US primary care setting. Social Science and Medicine: 52; 1343-1358.

Elderkin-Thompson, V., Waitzkin, H. (1999). Differences in clinical communication by gender. J Gen Intern Med: 14, 112-121.

Elwyne, G., Edward, A., Kinnersley, P. (1999). Shared decision making: the neglected second half of the consultation. Br J Gen Pract: 49; 477-482.

Emanuel, E.J., Emanuel, L.L. (1992). Four models of physician-patient relationship. JAMA: 267; 2221-2226.

Epstein, R.M., Alper, B.S., Quill, T.E. (2004). Communicating evidence for participatory decision-making. JAMA: 291; 2359-2366S

Eshet, I., Margalit, A., Almagor, G. (1993). SFAT-AM: Short Family Therapy in Ambulatory Medicine. Treatment approach in 10-15 minute encounters. Fam Pract: 10; 178-187.

Faden, R.R., Becker, C., Lewis, C., Freeman, J., Faden, A.I. (1981). Disclosure of information to patients in medical care. Med care: 19; 718-733.

Fairhurst, K., May, C. (2001). Knowing patients and knowledge about patients: evidence of modes of reasoning in the consultation? Fam Prct: 18; 501-505.

Fallowfield, L.J. (1993). Giving sad and bad news. Lancet: 341; 476-478.

Fallowfield, L.J. (1994). Information preferences of patients with cancer. Lancet: 344; 1576.

Fallowfield, L.J., Hall, A., Maguire, G.P., Baum, M.P. (1990). Psychological outcomes of different policies in women with early breast cancer outside a clinical trial. BMJ: 301; 575-580.

Fennema, K., Meyer, D.L., Owen, N. (1990). Sex of physician: patient preferences and stereotypes. J Fam Pract: 30; 441-446.

Fineman, N. (1991). The social construction of non-compliance: implications for cross-cultural geriatric practice. J Cross_Cult Geriontol: 6; 219-228.

Firkowska-Mankiewicz, A. (1991). Soviet medicine in the era of 'perestroyka': some notes on the Siberian conference on human health as an indicator of social development. Soc Sci Med: 32; 109-

Fisher, S. (1983). Doctor talk/patient talk: how treatment decisions are negotiated in doctor/patient communication. In S. Fisher, and A. Todd (eds). The social organization of doctor-patient communication (pp. 135-157). Washington, DC: Center for Applied Linguistics.

Fisher, S. (1991). A discourse of the social: medical talk/power talk/oppositional talk? Discourse and Society: 2; 157-182.

Fisher, W.R. (1984). Narration as a human communication paradigm: the case of public moral argument. Communication Monographs: 51; 1-22.

Fitzpatrick, R. (1984). Satisfaction with health care. In R. Fitzpatrick, J. Hinton, S. Newman, G. Scambler, and J. Thompson (eds). The experience of illness. (pp. 154-178). London: Tavistock.

Fitzpatrick, R. (1991a). Surveys of patient satisfaction: I- important general considerations. BMJ: 302; 887-889.

Fitzpatrick, R. (1991b). Surveys of patient satisfaction: II- designing a questionnaire and conducting a survey. BMJ: 302; 1129-1132.

Ford, R.C., Bach, S.A., Fottler, M.D. (1997). Methods of measuring patient satisfaction in health care organizations. Health Care Manage Rev: 22; 74-89.

Ford, S., Hope, T. (2003). Are patients' decision-making preferences being met? Health Expectations: 6; 72-80.

Foucault, M. (1975). The birth of the clinic: an archaeology of medical perception. New York: Vintage Books.

Freeman, G.K., Horder, J.P., Howie, J.G.R., Hungin, A.P., Hill, A.P., Shah, N.C., Wilson, A. (2002). Evolving general practice consultation in Britain: issues of length and context. BMJ: 324; 880-882.

Freemon, B., Negrete, V.F., Davis, M., and Korsch, B.M. (1971). Gaps in doctor-patient communication: doctor-patient interaction analysis. Pediatric Research: 5; 298-311.

Freidson, E. (1970). Professional dominance: the social structure of medical care. Chicago: Aldine.

Fuller, D., Quesada, G. (1973). Communication in medical therapeutics. J Comm: 23; 361-370.

Fuller, J., Toon, P. (1988). Medical practice in a multicultural society. London: Heinemann.

Gafni, A., Charles, C., Whelan, T. (1998). The physician patient encounter: the physician as the perfect agent for the patient versus the informed decision making model. Soc Sci Med: 47; 347-354.

Gallagher, E.B. (1976). Lines of reconstruction and extension in the Parsonian sociology of illness. Soc Sci Med: 10; 207-210.

Gandhi, I.G., Parle, J.V., Greenfield, S.M., Gould, S. (1997). A qualitative investigation into why patients change their GPs. Fam Pract: 14; 49-57.

Geertz, C. (1973). The interpretation of culture. New York: Basic Books.

Gianakos, D. (1996). Empathy revisited. Arch Intern Med: 156; 135-136.

Gibson, W. (1966). Tough, sweet and stuffy: an essay on modern American prose styles. Bloomington: Indiana University Press.

Giglio, J. (1993). The impact of patients' and therapists' religious values on psychotherapy. Hospital and Community Psychiatry: 44; 768-771.

Giles, H., Street Jr R.L. (1994). Communicator characteristics and behavior. In G.R. Miller, and M. Knapp (eds). Handbook of interpersonal communication (pp. 103-161). Newbury Park, CA: Sage.

Ginat, J. (1982). Women in muslim rural society: status and role in family and community. New Brunswick, NJ: Transaction Books

Goffman, E. (1959). The presentation of self in everyday life. New York: Doubleday.

Good, B. (1994). Medicine, rationality, and experience: an anthropological perspective. Cambridge: Cambridge University Press.

Gordon, D. (1990). Embodying illness, embodying cancer. Culture Med Psychiatry: 14; 275-297.

Gordon, D. (1996). MD's failure to use plain language can lead to the courtroom. Can Med Assoc J: 155; 1152-1154.

Gore, J., Ogden, J. (1998). Developing, validating and consolidating the doctor-patient relationship: the patients' views of a dynamic process. Br J Gen Pract: 48; 1391-1394.

Gorkin, M. (1986). Countertransference in cross-cultural psychotherapy: the example of Jewish therapist and Arab patient. Psychiatry: 49; 69-79.

Gorney, M. (1999). The role of communication in the physician's office. Clin Plastic Surg: 26; 133-141.

Gorter, S., Scherpbier, A., Brauer, J., Rethans, J.J., van der Heijde, D., Houben, H., van der Vleuten, C., van der Linden, S. (2002). Doctor-patient interaction: standardized patients' reflections from inside the rheumatological office. J Rheumatol: 29; 1496-1500.

Gotler, R.S., Flocke, S.A., Goodwin, M.A., Zyznski, S.J., Murray, T.H., Stange, K.C. (2000). Facilitating participatory decision-making. What happens in real-world community practice? Med Care: 38; 1200-1209.

Gray, B., Stoddard, J.J. (1997). Patient-physician pairing: does racial and ethnic congruity influence selection of a regular physician? J Community Health: 22; 247-259.

Gray, J. (1982). The effect of the doctor's sex on the doctor-patient relationship. J R Coll Gen Pract: 32; 167-172.

Gray, M. (1983). Communicating with elderly people. In D. Pendleton, and J. Hasler (eds). Doctor-patient communication (pp. 193-203). London: Academic Press.

Greco, M., Francis, W., Buckley, J., Brownlea, A., McGovern, J. (1998). Real-patient evaluation of communication skills teaching for GP registrars. Fam Pract: 15; 51-57.

Greenfield, S., Kaplan, S., Ware, J.E. Jr. (1985). Expanding patient involvement in care. Effects on patient outcomes. Annals Inter Med: 102; 520-528.

Greenhow, D., Howitt, A.J., Kinnersley, P. (1998). Patient satisfaction with referral to hospital: relationship to expectations, involvement, and information-giving in the consultation. British J Gen Pract: 48; 911-912.

Groenewegen, P. P., Hutten, J.B.F. (1991). Workload and job satisfaction among general practitioners: a review of the literature. Soc Sci Med: 32; 1111-1119.

Grol, R., de Maeseneer, J., Whitfield, M., Mokkink, H. (1990). Disease centred versus patient centred attitudes: comparison of general practitioners in Belgium, Britain and the Netherlands. Fam Pract: 7; 100-124.

Gropper, R.C. (1996). Culture and the clinical encounter: An international sensitizer for the health professions. Yarmouth, MN: Intercultural Press, Inc.

Gross, D.A., Zyzanski, S.J., Borawski, E.A., Cebul, R.D., Stange, K.C. (1998).Patient satisfaction with time spent with their physician. J Fam Prct: 47; 133-137.

Grover, G., Berkowitz, C.D., Lewis, R.J. (1994). Parental recall after a visit to the emergency department. Clin Pediatr: 33; 194-201.

Guadagnoli, E., Ward, P. (1998). Patient participation in decision making. Soc Sci Med: 47; 329-339.

Gudykunst, W.B., Ting-Toomey, S. (1988). Culture and interpersonal communication. Newbury Park, CA: Sage Pub, Inc.

Gulbrandsen, P., Hjortdahl, P., Fugelli, P. (1997). General practitioners' knowledge of their patients' psychosocial problems: multipractice questionnaire survey. BMJ: 314; 1014-1018.

Gwyn, R., Elwyn, G. (1999). When is a shared decision not (quite) a shared decision? Negotiation preferences in a general practice encounter. Soc Sci Med: 49; 437-337.

Haakana, M. (2001). Laughter as a patient's resource: dealing with delicate aspects of medical interaction. Text: 21; 187-219.

Haakana, M. (2002). Laughter in medical interaction: from quantification to analysis, and back. J Sociolinguistics: 6/2; 207-235.

Habermas, J. (1984). The theory of communicative action, reasons and rationalization of society. Vol.1. London: Heinemann.

Haddad, S., Potvin, L., Roberge, D., Pineault, R., Remondin, M. (2000). Patient perceptions of quality following a visit to a doctor in a primary care unit. Fam Pract: 17; 21-29.

Hahn, R.A. (1995). Sickness and healing. An anthropological perspective. New Haven: Yale University Press.

Hall, E.T. (1976). Beyond culture. New York: Doubleday.

Hall, E.T. (1984). The dance of life: The other dimensions of time. New York: Anchor Press.

Hall, J.A., Dornan, M.C. (1990b). Patient sociodemographic characteristics as predictors of satisfaction with medical care: a meta-analysis. Soc Sci Med: 30; 811-818.

Hall, J.A., Epstein, A.M., DeCiantis, M., McNeil, M. (1993). Physicians' liking for their patients: further evidence for the role of affect in medical care. Health Psychol: 12; 140-146.

Hall, J.A., Feldstein, M., Fretwell, M.D., Rowe, J.W., Epstein, A.M. (1990a). Older patients' health status and satisfaction with medical care in an HMO population. Med Care: 28; 261-270.

Hall, J.A., Horgan, T.G., Stein, T.S., Roter, D.L. (2002b). Liking in the physician-patient relationship. Patient Educ Couns: 48; 69-77.

Hall, J.A., Irish, J.T., Roter, D.L., Ehrlich, C.M., Miller, L.H. (1994a). Gender in medical encounters: an analysis of physician and patient communication in a primary care setting. Health Psychology: 13; 384-392.

Hall, J.A., Irish, J.T., Roter, D.L., Ehrlich, C.M., Miller, L.H. (1994b).Satisfaction, gender, and communication in medical visits. Med Care: 32; 1216-1231.

Hall, J.A., Roter, D.L. (2002a). Do patients talk differently to male and female physicians? A meta-analytic review. Patient Education and counseling: 48; 217-224.

Hall, J.A., Roter, D.L., Katz, N.R. (1987). Task versus socioemotional behaviors in physicians. Med Care: 25; 399-412.

Hall, J.A., Roter, D.L., Katz, N.R. (1988). Meta-analysis of correlates of provider behavior in medical encounters. Med Care: 26; 657-675.

Hall, S. (1992). New ethnicities. In J. Donald and A. Rattansi (eds). 'Race', culture and difference (pp. 252-259). London: Sage.

Hampers, L.C., Cha, S., Gutglass. D.J., Binns, H.J., Krug, S.E. (1999). Language barriers and resource utilization in a Pediatric Emergency Department. Pediatrics: 103; 1253-1256.

Hampton, J.R., Harrison, M.J.G., Mitchell, J.R.A., Prichard, J.S., Seymour, C. (1975). Relative contribution of history-taking, physical examination, and laboratory investigation to diagnosis and management of medical outpatients. BMJ: 2; 486-489.

Hardey, M. (1999). Doctor in the house: the Internet as a source of lay health knowledge and the challenge to expertise. Sociology of health and illness: 21; 820-835.

Haug, M. (1973). Deprofessionalization: an alternative hypothesis for the future. Sociological Review Monograph: 2; 195-211.

Heaney, D., Maxwell, M., Howie, J. (2002). Consultations should be longer. BMJ: 325; 1241.

Heilman, S.C., Witztum, E. (1994). Patients, chaperones and healers: enlarging the therapeutic encounter. Soc Sci Med: 39; 133-143.

Heisler, M., Bouknight, R.R., Hayward, R.A., Smith, D.M., Kerr, E.A. (2002). The relative importance of physician communication, participatory decision making, and patient understanding in diabetes self-management. J Gen Intern Med: 17; 243-252.

Helman, C.G. (1981). Disease versus illness in general practice. J. R. Coll. Gen. Pract: 31; 548-552.

Helman, C.G. (1985). Communication in primary care: the role of patient and practitioner explanatory models. Soc Sci Med: 20; 923-931.

Helman, C.G. (1987). Heart disease and the cultural construction of time: the type A behavior pattern as a Western culture-bound syndrome. Soc Sci Med: 25; 969-979.

Helman, C.G. (2001). Culture, health and illness. London: Arnold.

Henbest, R.J., stewart, M. (1990). Patient centeredness in the consultation. Part 2. Does it really make a difference? Fam Pract: 1990; 28-33.

Herskovits, M. (1955). Cultural anthropology. New York: Knopf.

Hofstede, G. (1980). Culture's consequences: international differences in work-related values. Beverly Hills, CA: Sage Pub.

Hoijer, H. (1988). The Sapir-Whorf Hypothesis. In L.A. Samovar and R.E. Porter (eds). Intercultural Communication: A Reader (pp. 225-232). Belmont, CA: Wadsworth, Inc.

Holden, C. (1981). Health care in the Soviet Union. Science: 213; 1090-1092.

Hooper, E.M., Comstock, L.M., Goodwin, J.M., and Goodwin, J.S. (1982). Patient characteristics that influence physician behavior. Med Care: 10; 630-638

Hopkins, E.J., Pye, A.M., Solomon, M., Solomon, S. (1967). A study of patient choice of doctor in an urban area. J R Coll Gen Pract: 66: 282-288.

Hornberger, J., Haruka, I., Wilson, S.R. (1997). Bridging language and cultural barriers between physicians and patients. Public Health Reports: 112; 410-417.

Hornberger, J.C., Gibson, C.D., Wood, W., Dequeldre,C., Corso,I., Palla, B., and Bloch, D.A. (1996). Eliminating language barriers for non-English-speaking patients. Med Care: 34; 845-856.

Houts, P.S., Yasko, J.M., Benham Kahn, S., Schelzel, G.W., Marconi, K.M. (1986). Unmet psychological, social, and economic needs of persons with cancer in Pennsylvania. Cancer: 58; 2355-2361.

Howard, D.L., Konrad, T.R., Stevens, C., Porter, C.Q. (2001). Physician-patient racial matching, effectiveness of care, use of services, and patient satisfaction. Research on aging: 23; 83-108.

Howell, E.A., Gardiner, B., Concato, J. (2002). Do women prefer female obstetricians? Obstet Gynecol: 99; 1031-1035.

Howie, J.G.R., Porter, A.M., Forbes, J.F. (1989). Quality and the use of time in general practice: widening the discussion. BMJ: 298; 1008-1010.

Hufford, D.J. (1997). Introduction. Southern Folklore: 54; 61-66.

Huges, T.E., Larson, L.Z.N. (1991). Patient involvement in health care: a procedural justice viewpoint. Med Care: 29; 297-303.

Hui, C., Triandis, H. (1986). Individualism-collectivism: a study of cross-cultural researchers. J Cross-Cultural Psychol: 17; 225-248.

Hulka, B.S., Zyzanski, S.J., Cassell, J.C. (1971). Satisfaction with medical care in a low income population. J Chron Dis: 24; 661-673.

Hull, F.M., Hull, F.S. (1984).Time and the general practitioner: the patient's view. J R Coll Gen Pract: 34; 71-75.

Hunter,J.D. (1994). Before the shooting begins: searching for democracy in America's culture war. New York: Free Press.

Illich, I. (1976). Limits to medicine: medical nemesis: the expropriation of health. London: Marion Boyars.

Inui, T.S., Carter, W.B., Kukull, W.A., Haigh, V.H. (1982). Outcome-based doctor-patient interaction analysis: comparison of techniques. Med Care: 20; 535-549.

Ishikawa, H., Takayama, T., Yamazaki, Y., Seki, Y., Katsumata, N. (2002). Physician-patient communication and patient satisfaction in Japanese cancer consultations. Soc Sci Med: 55; 301-311.

Jain, A., Ogden, J. (1999). General practitioners' experiences of patients' complaints: qualitative study. BMJ: 318; 1596-1599.

Jefferson, G., Sacks, H., Schegloff, E.A. (1987). Notes on laughter in the pursuit of intimacy. In G. Button, and J.R. Lee (eds). Talk and social organization (pp. 152-205). Clevedon, PA: Multilingual Matters Ltd.

Jenkins, L., Britten, N., Barber, N., Bradley, C.P., Stevenson, F.A. (2002). Consultations do not have to be longer. BMJ: 325; 388.

Johanson, M., Larsson, U.S., Saljo, R., Svardsudd, K. (1996). Addressing lifestyle in primary health care. Soc Sci Med: 43; 389-400.

Johanson, M., Larsson, U.S., Saljo, R., Svardsudd, K. (1998). Lifestyle discussionin the provision of health care. An empirical study of patient physician interaction. Soc Sci Med: 47; 103-112.

Jones, D., Gill, P. (1998). Breaking down language barriers: The NHS needs to provide accessible interpreting services for all. BMJ: 316; 1476.

Joos, S.K., Hickam, D.H., Borders, L.M. (1993). Patients' desires and satisfaction in general medicine clinics. Public Health Reports: 108; 751-759.

Kagawa-Singer, M., Kassim-Lakha, S. (2003) A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. Acad Med: 78; 577-587.

Kaplan, S.H., Gandek, B., Greenfield, S., Rogers, W., Ware, J.E. (1995). Patient and visit characteristics related to physicians' participatory decision-making style: Results from the Medical Outcomes Study. Med Care: 33; 1176-1187.

Kaplan, S.H., Greenfield, S., Gandek, M.S., Rogers, W.H., Ware Jr, J.E. (1996). Characteristics of physicians with participatory decision-making styles. Ann Intern Med; 124: 497-504.

Kaplan, S.H., Greenfield, S., Ware, J.E. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Med Care: 27(3 suppl); S110-S127.

Kassirer, J.P. (1983). Adding insult to injury. Usurping patients' prerogatives. New England J Med: 308; 898-901.

Kassirer, J.P. (1994). Incorporating patients' preferences into medical decisions. New England J Med: 330; 1895-1896.

Kasteller, J., Kane, R.L., Olsen, D.M., Thetford, C. (1976). Issues underlying prevalence of "doctor-shopping" behavior. J Health Soc Behav: 17: 329- 339.

Katriel, T. (1986). Talking straight: Dugri speech in Israeli Sabra culture. Cambridge: Cambridge University Press.

Katriel, T. (1991). Communal webs: communication and culture in contemporary Israel. Albany: State University of New York Press.

Katz, J. (2002). The silent world of doctor and patient. Baltimore, MD: Johns Hopkins University Press.

Katz, M. (2000). Constructing the "good patient" in conventional and unconventional medical settings: roles, relationships, and information transfer. Research in the sociology of health care: 18; 183-206.

Kaufert, J.M., Putch, R.W. (1997). Communication through Interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language, and power. J Clin Ethics: 8; 71-87.

Keating, N.L., Gandhi, T.K., Orav, E.J., Bates, D.W., Ayanian, J.Z. (2004). Patient characteristics and experiences associated with trust in specialist physicians. Arch Intern Med: 164; 1015-1020.

Keating, N.L., Green, D.C., Kao, A.C., Gazmaraian, J.A., Wu, V.Y., Cleary, P.D. (2002). How are patients' specific ambulatory care experiences related to trust, satisfaction, and considering changing physicians? J Gen Intern Med: 17; 29-39.

Keeler, E.B., Solomon, D.H., Beck, J.C., Mendenhall, R.C., Kane, R.L. (1982). Effect of patient age on duration of medical encounters with physicians. Med Care: 20; 1101-1108.

Kelly, J.M. (1980). Sex preferences in patient selection of family physician. J Fam Pract: 11; 427-430.

Kerssesns, J.J., bensing, J.M., Andela, M.G. (1997). Patient preference for genders of health professionals. Soc Sci Med: 44; 1531-1540.

Kessing, R. (1974). Theories of culture. Annual Rev Anthropol: 3; 73-97.

Kim, Y.Y. (1991). Communication and adaptation. In L.A. Samovar, and R.E. Porter (eds) .Intercultural communication: A reader (pp. 383-391). Belmont,CA: Wadsworth, Inc.

King, L.S. (1982). Medical thinking. A historic preface. Princeton, NJ: Princeton University Press.

Kinnerrsley, P., Scott, N., Peters, T., Harvey, I., Hackett, P. (1996). A comparison of methods for measuring patient satisfaction with consultations in primary care. Fam Pract: 13; 41-51.

Kirkman-Liff, B., Mondragon, D. (1991). Language of interview: Relevance for research of Southwest Hispanics. Am J Pub Health: 81; 1399-1414.

Kleinman, A. (1978b). Clinical relevance of anthropological and cross-cultural research: concepts and strategies. Am J Psych: 135; 427-431.

Kleinman, A. (1980). Patients and healers in the context of culture. Berkeley: University of California Press.

Kleinman, A. (1988). The illness narratives. New York: Basic books.

Kleinman, A., Eisenberg, L., Good, B. (1978a). Culture, illness, and care: clinical lessons from anthropologic and cross cultural research. Annals Intern Med: 88; 251-258.

Kluckhohn, F, Strodtbeck, F.L. (1960). Variations in value orientations. Westport, Conn: Greenwood Press.

Kochman, T. (1981). Black and white styles in conflict. Chicago: University of Chicago Press.

Komaromay, M., Grumbach, K., Drake, M., Lurie, N., Keane, D., Bindman, A.B. (1996). The role of Black and Hispanic physicians in providing health care for underserved populations. New Engl J Mrd: 334; 1305-1310.

Korsch, B., Gozzi, E., Francis, V. (1968). Gaps in doctor-patient communication. Pediatrics: 42; 855-871.

Korsch, B., Negrete, V.F. (1972). Doctor-patient communication. Scientific America: 227; 66-74.

Korsch, B., Negrete, V.F. (1981). Doctor-patient communication. In G. Henderson (ed). Physician-patient communication: readings and recommendations (pp. 29-40). Springfield, IL: Thomas.

Koss, T., Rosenthal, R. (1997). Interactional synchrony, positivity, and patient satisfaction in the physician-patient relationship. Med Care: 35; 1158-1163.

Kravitz, R.L., Callahan, E.J., Azari, R., Antonius, D., Lewis, C.E. (1997). Assessing patients' expectations in ambulatory medical practice. Does the measurement approach make a difference? J Gen Intern Med: 12; 67-72.

Kreps, G., Thornton, B. (1984). Health communication. New York: Longman.

Kreps, G.L (1993). Relational communication in health care. In B.C Thornton, and G.L. Kreps (eds). Perspectives on health communication (pp.51-65). Prospect Heights, IL: Waveland Press, Inc.

Kreps, G.L. (1988). The pervasive role of information in health and health care: implications for health communication policy. In J. Anderson (ed). Communication yearbook: 11; 238-276.

Kreps, G.L. (1990). Communication and health education. In E. Berlin Ray, and L. Donohew (eds). Communication and health: Systems and applications (pp.187-203). Hillsdale, NJ: Lawrence Erlbaum Ass. Pub.

Kreps, G.L., Kunimoto, E.N. (1994). Effective communication in multicultural health settings. Thousand oaks: Sage Pub.

Kreps, G.L., Thornton, B.C. (1992). Health communication: Theory and practice. Prospect Hills, IL: Waveland Press, Inc.

Krupat, E., Rosenkranz, S.L., Yeager, C.M., Barnard, K. Putman, S.M., Inui T.M. (2000). The practice orientations of physicians and patients: the effect of doctor-patient congruence on satisfaction. Patient Educ Couns: 39; 49-59.

Laine, C., Davidoff, F., Lewis, C.E., Nelson, E.C., Nelson, E., Kessler, R.C., Delbanco, T.L. (1996). Important elements of outpatient care: a comparison of patients' and physicians' opinions. Ann Intern Med: 125; 640-645.

Landen, C.N., Younger, N.O., Collins Sharp, B.A., Underwood, P.B. (2003). Cancer patients' satisfaction with physicians: Princess Margaret hospital satisfaction with doctor questionnaire results. Am J Obstet Gynecol: 188; 1177-1179.

Larson, B.D., Sherrill, K.A., Lyons, J.S. (1992). Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978-1989. Am J Psychiatry: 149; 557-559.

Larsson, U.S., Svaedsudd, K., Wedel, H., Saljo, R. (1989). Patient involvement in decision-making in surgical and orthopedic practice: the project preoperative risk. Soc Sci Med: 28; 829-835.

Laveist, T.A., Nuru-Jeter, A. (2002). Is doctor-patient race-concordance associated with greater satisfaction with care? J Health Soc Behav: 43; 296-306.

Lazare, A., Eisenthal, S., Frank, A., Stoeckle, J. (1978). Studies on a negotiated approach to patienthood. In E.B. Gallagher (ed). The doctor-patient relationship in the changing health scene (pp. 119-139). Washington, DC: DHEW Pub.

Lebow, J.L. (1974). Consumer assessment of the quality of medical care. Med Care: 12; 328-337.

Lee, H.A. (2002b). Longer consultations can improve patient satisfaction. BMJ: 325; 1241-1242.

Lee, L.J., Batal, H.A., Maselli, J.h., Kutner, J.S. (2002a). Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. J Gen Intern Med: 17; 641-646.

Lee, R.G., Garvin, T. (2003). Moving from information transfer to information exchange in health and health care. Soc Sci Med: 56; 449-464.

Leopold, N., Cooper, J., Clancy, C. (1996). Sustained partnership in primary care. J Fam Pract: 42; 129-137.

Leshem, E., Sicron, M. (1999). The absorption of Soviet immigrants in Israel. In D. Singer, and R. Seldin (eds). American Jewish Yearbook 1999 (pp. 448-522). New York: American Jewish Committee.

Leshem, E., Sor, D. (1997). Immigration and absorption of former Soviet Union Jewry: selected bibliography and abstracts, 1994-1996. Jerusalem: Henrietta Szold Institute and Hebrew University.

Levenstein, J.H., McCracken, E.C., McWhinney, I.R., Stewart, M.A., Brown, M.A., Brown, J.B. (1986). The patient centred clinical method. Part 1. A model for the doctor-patient interaction in family medicine. Fam Pract: 3; 24-30.

Levine, J.S. (2004). Trust: can we create the time? Arch Intern Med: 164; 930-932.

Levinson, W., Chaumenton, N. (1999). Communication between surgeons and patients in routine office visits. Surgery: 152; 127-134.

LeVois, M., Nguyen, T.D., Attkinsson, C.C. (1981). Artifact in client satisfaction assessment: experience in community mental health setting. Evaluation and Program Planning: 4; 139-150.

Levy, D.R. (1985). White doctors and black patients: influence of race on the doctor-patient relationship. Pediarics: 75; 639-643.

Ley, P. (1972). Complaints made by hospital staff and patients: a review of the literature. Bulletin of British Psychologists: 25; 115-120.

Ley, P. (1983). Patients' understanding and recall in clinical communication failure. In D. Pendleton, and J. Hasler (eds). Doctor-patient communication (pp.89-107). London: Academic Press.

Ley, P., Spelman, M.S. (1967). Communicating with the patient. London: Staples Press.

Lieberman, P.B., Sledge, W.H., Matthews, D.A. (1989). Effect of patient gender on evaluation of intern performance. Arch Intern Med: 149; 1825-1829.

Like, R., Zyzanski, S.J. (1987). Patient satisfaction with the clinical encounter: Social psychological determinants. Soc Sci Med:24; 351-357.

Lin, C.T., Albertson, G.A., Schilling, L.m., Cyran, E.M., Anderson, S.N., Ware, L., Anderson, R.J. (2001). Is patients' perception of time spent with the physician a determinant of ambulatory patient satisfaction? Arch Intern Med: 161; 1437-1442.

Lin, E.H. (1983). Intraethnic characteristics and the patient-physician interaction: "cultural blind spot syndrome". J Fam Pract: 16; 91-98

Linder-Pelz, S., Struening, E.L. (1985). The multidimensionality of patient satisfaction with a clinic visit. J Community Health: 10; 42-53.

Lindgren, H.C., Tebcherani, A. (1971). Arab and American auto-and heterostereotypes: a cross-cultural study of empathy. J Cross-Cultural Psychol: 2; 173-180.

Lindquist, G. (2001). The culture of charisma: wielding legitimacy in contemporary Russian healing. Anthropology Today: 17; 3-9.

Linn, L.S., Cope, D.W., Leake, B. (1984). The effect of gender and training of residents on satisfaction ratings by patients. J Med Educ: 59; 964-966.

Linn, L.S., Greenfield, S. (1982). Patient suffering and patient satisfaction among the chronically ill. Med Care: 20; 425-431.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K. (2001). Preferences of patients for patient centered approach to consultation in primary care: observational study. BMJ: 322; 468-472.

Lloyd, M., Bor, R. (2004). Communication skills for medicine. Edinburgh: Churchill Livingstone.

Lochman, J.E. (1983). Factors related to patients' satisfaction with their medical care. J Community Health: 9; 91-109.

Locker, D., Dunt, D. (1978). Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. Social Science and Medicine; 12: 283-292.

Logan, P.D., Schwab, R.A., Salomone, J.A., Watson, W.A. (1996). Patient understanding of emergency department discharge instructions. South Med J: 89; 770-774.

Loustaunan, M.O., Sobo, E.J. (1997). The cultural context of health, illness, and medicine. Westport, CT: Bergin and Garvey.

Lowenthal, K.M., Goldblatt, V. (1993). Family size and depressive symptoms in orthodox Jewish women. J Psychiatric Researh: 27; 3-10.

Luckmann, J. (2000). Transcultural communication in health care. New York: Delmar Thomson Learning.

Lupton, D. (1994). Medicine as culture. Illness, disease and the body in Western societies. London: Sage.

Lupton, D. (1997). Consumerism, reflexivity and medicine. Soc Sci Med: 43; 373-381.

Madhok, R., Bhopal, R.S., Ramaiah, R.S. (1992). Quality of hospital service: a study comparing "Asian" and "non-Asian" patients in Middlesborough. J Pub Health Med: 14; 271-279.

Maheux, B., Dufort, F., Beland, F., Jacques, A., Levesque, A. (1990). Female medical practitioners: more preventive and patient oriented? Med Care: 28; 87-92.

Malat, J. (2001). Social distance and patients' rating of healthcare providers. J Health Soc Behav: 42; 360-372.

Malterud, K. (1994). Women's undefined disorders- a challenge for clinical communication. Fam Pract: 9; 299-303.

Malterud, K. (1999). The gendered construction of diagnosis interpretation of medical signs in women patients. Theoretical Med and Bioethics: 20; 275-286.

Maly, R.C., Leake, B., Silliman, R.A. (2003). Health care disparities in older patients with breast carcinoma. Informational support from physicians. Cancer: 97; 1517-1527.

Maly, R.C., Leake, B., Silliman, R.A. (2004b). Breast cancer treatment in older women: impact of the patient-physician interaction. J Am Geriatr Soc: 52; 1138-1145.

Maly, R.C., Umezawa, Y., Leake, B., Silliman, R. (2004a). Determinants of participation in treatment decision-making by older breast cancer patients. Breast Cancer Research and treatment: 85; 201-209.

Manson, A. (1988). Language concordance as s determinant of patient compliance and Emergency Room use in patients with Asthma. Med Care: 26; 1119-1128.

Marinker, M., Blenkinsopp, A., Bond, C., Britten, N., Feely, M., George., C. (1997). From compliance to concordance. Achieving shared goals in medicine taking. London: Royal Pharmaceutical Society of Great Britain.

Marquis, M.S., Ross Davies, A., Ware, J.E. (1983). Patient satisfaction and change in medical care provider: a longitudinal study. Med Care: 21; 821-829.

Martin, A.R. (1983). Exploring patient beliefs. Steps to enhancing physician-patient interaction. Arch Intern Med: 143; 1773-1775.

Marvel, M.K., Epstein, R.M., Flowers, K., Beckman, H.B. (1999). Soliciting the patient's agenda: have we improved? JAMA: 281; 283-287.

Matthews, D., McCullough, M., Larson, D., Koenig, H., Swyers, J., Milano, M. (1998). Religious commitment and health status: a review of the research and implications for family medicine. Arch Inter Med: 7; 118-124.

McIntosh, A., Shaw, C.F.M. (2003). Barriers to patient information provision in primary care: patients' and general practitioners' experiences and expectations of information for low back pain. Health Expectations: 6; 19-29.

McKeown, R.E., Reininger, B.M., Martin, M., Hoppmann, R.A. (2002). Shared decision making: views of first-year residents and clinic patients. Acad Med: 77; 438-445.

McKinlay, J.B., Stoeckle, J.D. (1988). Corporatization and the social transformation of doctoring. International Journal of Health Services: 18; 191-205.

McKinstry, B., Walker, J., Campbell, C., Heaney, D., Wyke, S. (2002). Telephone consultations to manage requests for same day appointments: a randomized controlled trial in two practices. BR J Gen Pract: 52; 306-310.

McLaughlin, L.A., Braun, K.L. (1998). Asian and Pacific Islander cultural values: considerations for health care decision making. Health & Social Work: 23; 116-126.

McNeil, C. (1990). Culture: the impact on health care. J Cancer Educ: 5; 13-16.

McQueen, R., Knussen, C. (2002). Research methods for social science. An introduction. London: prentice Hall.

Meakin, R., Weinman, J. (2002). The 'medical interview satisfaction scale' (MISS-21) adapted for British general practice. Fam Pract: 19; 257-263.

Mechanic, D. (1979). Future issues in health care: social policy and the rationing of medical services. New York: The Free Press.

Mechanic, D. (2001b). How should hamsters run? Some observations about sufficient patient time in primary car. BMJ: 323; 266-268.

Mechanic, D., McAlpine, D., and Rosenthal, M. (2001a). Are patients' office visits with physicians getting shorter? N Engl J Med: 344; 198-204.

Mercer, S.W., Hasegawa, H., Reilly, D., Bikker, A.P. (2002a). Time and stress are limiting holistic care in Scotland. BMJ: 325; 1242.

Mercer, S.W., Reilly, D. (2004). A qualitative study of patient's views on the consultation at the Glasgow homoeopathic hospital, an NHS integrative complementary and orthodox medical care unit. Patient Educ Couns: 53; 13-18.

Mercer, S.W., Reynolds, W. (2002b). Empathy and quality of care. Br J Gen Pract: 52(suppl); S9-S12.

Merkel, W.T. (1984). Physician perception of patient satisfaction: do doctors Know which patients are satisfied? Med Care: 22; 453-459.

Meyers, C. (2004). Cruel choices: autonomy and critical care decision-making. Bioethics: 18; 104-119.

Mishler, E. (1984). The discourse of medicine: the dialectics of medical interviews. Norwood, NJ: Ablex.

Morales, L.S., Cunningham, W.E., Brown, J.A., Liu, H., Hays, R.D. (1999). Are Latinos lass satisfied with communication by health care providers. J Gen Intern Med: 14; 409-417.

Morrell, D.C., Evans, M.E., Morris, R.W., Roland, M.O. (1986). The "five minute" consultation: effect of time constraint on clinical content and patient satisfaction. BMJ: 292; 870-873.

Morrell, D.C., Roland, M.O. (1987). How can good general practitioner care be achieved? BMJ: 294; 161-162.

Murphy, S.T., Palmer, J.M., Azen, S., Franks, G., Michel, V., Blackhall, L.J. (1996). Ethnicity and advance directives. J Law Med Ethics: 24; 108-117.

Neuberger, J. (2000). The educated patient: new challenges for the medical profession. J Inten Med: 247; 6-10.

Ngo-Metzger, Q., Massagli, M.P., Clarridge, B.R., Manocchia, M., Davis, R.B., Lezzoni, L.I., Phillips, R.S. (2003). Linguistics and cultural barriers to care perspectives of Chinese and Vietnamese immigrants. J Gen Intern Med: 18; 44-52.

O'Connor, B.B. (1997). Applying folklore in medical education. Southern Folklore: 54; 67-77.

O'Keefe, M., Sawyer, M., Roberton, D. (2001). Medical student interviewing skills and mother-reported satisfaction and recall. Med Educ: 35; 637-644.

Ogden, J., Ambrose, L., Khadra, A., Manthri, S., Symons, L., Vaas, A., Williams, M. (2002). A questionnaire study of GPs' and patients' beliefs about the different components of patient centredness. Patient Educ Couns: 47; 223-227.

Okabe, R. (1983). Cultural assumptions of East and West: Japan and the United States. In W. Gudykunst (ed.). Intercultural communication theory (pp.36-44). Beverly Hills, CA: Sage Pub, Inc.

Ong, L.M., de Haes, J.C.J.M., Hoos, A.M., Lammers, F.B. (1995). Doctor-patient communication: A review of the literature. Soc Sci Med: 40; 903-918.

Owen, C. (1991). Formal complaints against general practitioners: a study of 1000 cases. Br J Gen Pract: 41; 113-115.

Owens, D.J., Batchelor, C. (1996). Patient satisfaction and the elderly. Soc Sci Med: 42; 1483-1491.

Parascandola, M., Hawkins, J., Danis, M. (2002). Patient autonomy and the challenge of clinical uncertainty. Kennedy Institute of Ethics Journal: 12; 245-264.

Parsons, T. (1951). The social system. Glencoe, IL: The Free Press.

Parsons, T. (1987). Illnes and the role of the physicians: a sociological perspective. In J.D. Stoeckle (ed). Encounters between patients and doctors: an anthology (pp.15-19). Cambridge, MA: MIT Press.

Pascoe, G.C. (1983). Patient satisfaction in primary health care: a literature review and analysis. Evaluation and Program Planning: 6; 185-210.

Pasick, R.J., D'Onofrio, C.N., Otero-Sabogal, R. (1996). Similarities and differences across culture: questions to inform a third generation for health promotion research. Health Educ Q: 23; S142-S161.

Patai, R. (1983). The Arab mind. New York: Charles Scibner's Sons.

Patton, M.Q. (1990). Qualitative evaluation and research methods. Newbury Park, CA: Sage.

Pauwels, A. (1995). Cross-cultural communication in the health sciences. Communicating with migrant patients. Melbourne: Macmillan Education Australia Ltd.

Pearson, J.C. (1988). Gender and communication: sex is more than a three-letter word. In L.A. Samovar and R.E. Porter (eds). Intercultural Communication: A Reader (154-162). Belmont, CA: Wadsworth, Inc.

Peck, B.M., Asch, D.A., Goold, S.D., Roter, D.L., Ubel, P.A., McIntre, L.M., Abbott, K.H., Hoff, J.A., Koropchak, C.M., Tulsky, J.A. (2001). Measuring patient expectations. Does the instrument affect satisfaction or expectations? Med Care: 39; 100-108.

Pendleton, D., Bochner, S. (1980). The communication of medical information in general practice consultations as a function of patients' social class. Soc Sci Med: 14A; 669-673.

Pendleton, D., Hasler, J. (1983). Doctor-patient communication. London: Academic Press.

Perez-Stable, E.J., Napoles-Springer, A. (2000). Interpreters and communication in the clinical encounter. Am J Med: 108; 509-510.

Perez-Stable, E.J., Napoles-Springer, A., Miramontes, J.M. (1997). The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. Med Care: 35; 1212-1219.

Pettegrew, L. (1977). An investigation of therapeutic communication style. In B. Ruben (ed). Communication Yearbook (pp. 593-604). New Brunswick, NJ: Transaction.

Pfifferling, J. (1981). A cultural prescription for medicocentrism. In L. Eisenberg, and A. Kleinman (eds). The relevance of social science for medicine (pp. 197-222). Dodrecht, Holland: D. Reidel Pub Co.

Phelan, M., Parkman, S. (1995). Work with an interpreter. BMJ: 311; 555-557.

Plotnikoff, G.A., Barnes, L.L. (2000). Cross-cultural primary care. Letter. Annals Intern Med: 132: 164-164.

Pluchman, M. (1978). Human communication: the matrix of nursing. New York: McGraw-Hill.

Pointon, T. (1996). Telephone interpreting service is available. BMJ: 312; 53.

Porter, J.R., Beuf, A.H. (1994). The effect of a racially consonant medical context on adjustment of African-American patients to physical disability. Medical Anthropology: 16; 1-16.

Porter, R.E., Samovar, L.A. (1988). Approaching intercultural communication. In L.A. Samovar, and R.E. Porter. (1988). Intercultural communication: A reader (pp.15-30). Belmont, CA: Wadsworth, Inc.

Poulton, B. (1996). Use of the consultation satisfaction questionnaire to examine patients' satisfaction with general practitioners and community nurses: reliability, replicability and discriminant validity. Br J Gen pract: 46; 26-31.

Purtilo, R., Haddad, A. (2002). Health professional and patient interaction. Philadelphia, Penn: W.B. Saunders Com.

Putsch, R.W. (1985). The special case of interpreters in health care. JAMA: 254; 3344-3348.

Quill, T.E. (1983). Partnership in patient care: a constructual approach. Annals Intern Med: 98; 228-234.

Quirt, C.F., Mackillop, W.J., Ginsburg, A.D., Sheldon, L., Brundage, M., Dixon, P., Ginsburg, L. (1997). Do doctors know when their patients don't? A survey of doctor-patient communication in lung cancer. Lung Cancer: 18; 1-20.

Rack, P. (1982). Race, culture and mental disorder. London: Tavistock.

Raphael, W. (1967). Do we know what patients think? International J Nursing Studies: 4; 209-223.

Reeder, L.G. (1972). The patient-client as a consumer: some observations on the changing professional-client relationship. J health Soc Behav: 13; 406-412.

Reiff, M., Zakut, H., Weingarten, M.A. (1999). Illness and treatment perceptions of Ethiopian immigrants and their doctors in Israel. Am J Public Health: 89; 1814-1818.

Remennick, L.I., Ottenstien-Eisen, N. (1998). Reaction of new immigrants to primary health care services in Israel. Internl J Health Services: 28; 555-574.

Remennick, L.I., Shtarkshall, R.A. (1997). Technology versus responsibility: immigrant physicians from the FSU reflect on Israeli health care. J Health Soc Behav: 38; 191-202.

Risko, A. (1992). Non-verbal communication between cancer patients and "others". Psych-Oncol Lett: 3; 15.

Rispler-Chaim, V. (1993). Islamic medical ethics in the twentieth century. Leiden: Brill Academic Pub.

Rivadeneyra, R., Elderkin-Thompson, V., Cohen Silver, R., Waitzkin, H. (2000). Patient centeredness in medical encounters requiring an interpreter. Am J Med: 108; 470-474.

Robbins, J.A., Bertakis, K.D., Helms, L.J., Azari, R., Callahan, E.J., Creten, D.A. (1993).The influence of physician practice behaviours on patient satisfaction. Fam Med: 25; 17-20.

Roberts, C.A., Arguete, M.S. (2000b). Task and emotional behaviors of physicians: a test of reciprocity and social interaction theories in analogue physician-patient encounters. Soc Sci Med: 50; 309-315.

Roberts, F. (2000a). The interactional construction of asymmetry: the medical agenda as a resource for delaying response to patient questions. The Sociological Quarterly: 41; 151-170.

Robinson, E.J., Whitfield, M.J. (1985). Improving the efficiency of patients' comprehension monitoring: a way of increasing patients' participation in general practice consultations. Soc Sci Med: 21; 915-919.

Robinson, J. D. (2001). Closing medical encounters: two physician practices and their implications for the expression of patients' unstated concerns. Soc Sci Med: 53; 639-656.

Roland, M. (2002). Contract needs to enable doctors to offer first class care. BMJ: 325; 1241.

Roland, M.O., Bartholomew, J., Courtenay, M.J.F., Morris, R.W., Morrell, D.C. (1986). Br Med J: 292; 874-876.

Rosenheck, R., Fontana, A., Cottrol, C. (1995). Effect of clinician-veteran racial pairing in the treatment of posttraumatic stress disorder. Am J Psych: 152; 555-563.

Rosenstock, I.M. (1966). Why people use health services. Milbank Memorial Fund Quarterly: 44; 94-127.

Ross, C.K., Steward, C.A., Sinacore, J.M. (1995). A comparative study of seven measures of patient satisfaction. Med Care: 33; 392-406.

Roter, D.L. (1977). Patient participation in the patient-provider interaction: the effects of patient question asking on the quality of interaction, satisfaction and compliance. Health Educ Monographs: 5; 281-315.

Roter, D.L., Geller, G., Bernhardt, B.A., Larson, S.M., Doksum, T. (1991b). Effects of obstetrician gender on communication and patient satisfaction. Obstet Gynecol: 93; 635-641.

Roter, D.L., Hall, J.A. (1992). Doctors talking with patients/ patients talking with Doctors. Westport, CT: Auburn House.

Roter, D.L., Hall, J.A. (1998). Why physician gender matters in shaping the physician-patient relationship. J Womens Health: 7; 1093-1097.

Roter, D.L., Hall, J.A. (2004). Physician gender and patient-centered communication: A critical review of empirical research. Annu Rev Public Health: 25; 497-519.

Roter, D.L., Hall, J.A., (1989). Studies of doctor-patient interaction. Ann Rev Pub Health: 10; 163-180.

Roter, D.L., Hall, J.A., Aoki, Y. (2002). Physician gender effects in medicalcommunication: A meta-analytic review. JAMA: 288; 756-764.

Roter, D.L., Hall, J.A., Katz, N.R. (1987). Relations between physicians' behaviors and analogue patients' satisfaction, recall, and impressions. Med Care: 25; 437-451.

Roter, D.L., Lipkin, m., Korsgaard, A. (1991a). Sex differences in patients' and physicians' communication during primary care medical visits. Med Care; 29: 1083-1093.

Roter, D.L., Stewart, M., Putnam, S.M., Lipkin, M., Stiles, W., Inui, T.S. (1997). Communication patterns of primary care physicians. JAMA: 277; 350-356.

Ruben, B.D. (1990). The health caregiver-patient relationship: pathology, etiology, treatment. In E. Berlin Ray, and L. Donohew (eds). Communication and health: Systems and applications (pp.51-68). Hillsdale, NJ: Lawrence Erlbaum Ass. Pub.

Ruhnke, G.W., Wison, S.R., Akamatsu, T., Kinoue, T., Takashima, Y., Goldstein, M.K., Koenig, B.A., Hornberger, J.C., Raffin, T.A. (2000). Ethical decision making and patient autonomy. A comparison of physicians and patients in Japan and the United States. Chest: 118; 1172-1182.

Sacks, H. (1992). Lectures on conversation. Vol. 1 and 2. Oxford: Blackwell.

Safran, D.G., Taira, D.A., Rogers, W.H., Kosinski, M., Ware, J.E., Tarlov, A.R. (1998). Linking primary care performance to outcomes of care. J Fam Pract: 47; 213-220.

Saha, S., Komaromy, M., Koepsell, T.D., Bindman, A.B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. Arch Intern Med: 159; 997-1004.

Saha, S., Taggart, S.H., Komaromy, M., Bindman, A.B. (2000). Do patients choose physicians of their own race? Health Affairs: 19; 76-83.

Samora, J., Saunders, L., Larson, R.F. (1961). Medical vocabulary knowledge among hospital patients. J Health and Human Behav: 2; 83-92.

Samovar, L.A., Porter, R.E. (1988). Intercultural communication: A reader. Belmont,CA: Wadsworth, Inc.

Samovar,L.A., Porter,R.E., Jain, N.C. (1981). Understanding intercultural communication. Belmont, CA: Wadsworth, Inc.

Schmittdiel, J., Grumbach, K., selby, J.V., Quesenberry, C.P. (2000). Effect of physician and patient gender concordance on patient satisfaction and preventive care practices. JGIM: 15; 761-769.

Schneider, C.E. (1998). The practice of autonomy: patients, doctors and medical decisions. New York: Oxford University Press.

Schreiber, K. (1991). Religion in the physician-patient relationship. JAMA: 266; 3062-3066.

Schutz, S.M., Lee, J.G., Schmitt, C.M., Almon, M., Baillie, J. (1994). Clues to patient dissatisfaction with conscious sedation for colonoscopy. Am J Gastro: 89; 1476-1479.

Scully, D., Bart, P. (1978). :A funny thing happened on the way to the office: Women in Gynecology textbooks". In J. Ehrenreich (ed). The cultural crisis of modern medicine (pp. 212-226). New York: Monthly Review Press.

Seijo, R., Gomez, H., Friedenberg, J. (1991). Language as a communication barrier in medical care for Latino patients. Hisp J Behav Sci: 13; 363-366.

Semyonov, M., Tyree, A. (1981). Community segregation and the cost of ethnic subordination. Social Forces: 59; 649-666.

Sered, S., Tabory, E. (1999). "You are a number, not a human being": Israeli breast cancer patients' experiences with the medical establishment. Med Anthropol Quart: 13; 223-252.

Shapiro, J. (1999). Correlates of family-oriented physician communications. Fam Pract: 16; 294-300.

Shaw, I. (1976). Consumer opinion and social policy: a research review. J Soc Pol: 5; 19-32.

Sheiner, E.K., Sheiner, E., Shoham-Vardi, I., Mazor, M., Katz, M. (1999). Ethnic differences influence care giver's estimates of pain during labor. Pain: 81; 299-305.

Shilling, C. (1991). Educating the body: physical capital and production of social inequalities. Sociology: 25; 653-672.

Shokeid, M. (1980). Ethnic identity and the position of women among Arabs in an Israeli town. Ethnic Racial Studies: 3; 188-206.

Shouby, E. (1970). The influence of the Arabic language on the psychology of the Arabs. In A. Lutfiyya and C. Churchill .. Readings in Arab Middle Eastern societies and cultures (pp.688-703) The Hague: Mouton.

Shuval, J.T. (1983). Newcomers and colleagues: Soviet immigrant physicians in Israel. Houston, TX: Cap and Gown Press.

Shuval, J.T. (1989). The structure and dilemmas of Israeli pluralism. In B. Kimmerling (ed). The Israeli state and society (pp.216-236). Albany: State University of New York Press.

Shuval, J.T. (1992). Social dimensions of health. The Israeli experience. Westport, CT: Praeger.

Silverman, D. (1987). Communication and medical practice: social relations and the clinic. London: Sage Pub.

Silverman, D. (2001). Interpreting qualitative data. Methods for analyzing talk, text and interaction. London: Sage Pub.

Silverstein, R. (1995). Bending the conventional rules when treating the ultra-orthodox in the group setting. Intrenatl J Group Psychotherapy: 45; 237-249.

Sitzia, J., Wood, N. (1997). Patient satisfaction: a review of issues and concepts. Soc Sci Med: 45; 1829-1843.

Slack, W.V. (1977). The patient's right to decide. Lancet: 2; 240.

Sloane, P. (1991). Experiences and expectations of government services to the older Soviet emigrant. J Cross-Cult Gerontol: 6; 193-197.

Smith, R.C., Hoppe, R.B. (1991). The patient's story: integrating the patient-and physician-centered approaches to interviewing. Annals Intern Med: 115; 470-477.

Smooha, S. (1978). Israel: pluralism and conflict. London: Routledge and Kegan Paul.

Sodowsky, G.R., Taffe, R.C. (1991). Counselor trainees' analyses of multicultural counseling videotapes. J Multicultural Couns Develop: 19; 115-129.

Spector, R.E. (2000). Cultural diversity in health and illness. Upper Saddle River, N.J: Prentice Hall Health.

Spero, M.H. (1981). Clinical note on the management of 'religious' resistances in orthodox Jewish clientele. J Jewish Communal Service: 57; 334-341.

Spero, M.H. (1983). Modern psychotherapy and halakhic ethics: an approach toward consensus in values and practices. J Med Phil: 8; 81-110.

Stange, K.C., Zyzanski, J., Jaen, C.R. Callahan, E.J., Kelly, R.B., Gillamnders, W.R., Shank, J.C., Chao, J., Medalie, J.H., Miller, W.L., Crabtree, B.F., Flocke, S.A., Gilchrist, V.J., Lange, D.M., Goodwin, M.A. (1998). Illuminating the "Black Box": A description of 4454 patient visits to 138 family physicians. J Fam Pract: 46; 377-389.

Starr, P. (1982). The social transformation of American medicine. New York: Basic Books.

Stevens, J. (1986). Applied multivariate statistics for the social sciences. Hillsdale, NJ: Lawrence Erlbaum Associates,Pub.

Stevenson, F., Scambler, G. (2005). The relationship between medicine and the public: the challenge of concordance. Health: 9; 5-21.

Stevenson, F.A., Barry, C.A., Britten, N., Barber, N., Bradley, C.P. (2000). Doctor-patient communication about drugs: the evidence for shared decision making. Soc Sci Med: 50; 829-840.

Stewart, M.A. (1984). What is a successful doctor-patient interview? A study of interactions and outcomes. Soc Sci Med: 19; 167-1975.

Stewart, M.A. (1995). Effective physician-patient communication and health outcomes: a review. Can Med Assoc J: 152; 1423-1433.

Stewart, M.A., Brown, J.B., Donner, A., McWhinney, I.R., Oates, J., Weston, W.W., Jordan, J. (2000). The impact of patient-centered care on outcomes. J Fam Pract: 49; 796-811.

Stiggelbout, A.M., Kiebert, G.M. (1997). Patient preferences regarding information and participation in clinical decision-making. Can Med Assoc J: 157; 383-389.

Stiles, W.B. (1978). Verbal response modes and dimensions of interpersonal roles: a method of discourse analysis. J Personality Soc Psychol: 36; 693-703.

Stiles, W.B., Putnam, S.M., Wolf, M.H., James, S.A. (1979a). Interaction exchange structure and patient satisfaction with medical interviews. Med Care: 17; 667-681.

Stiles, W.B., Putnam, S.M., Wolf, M.H., James, S.A. (1979b). Dimensions of patient and physician roles in medical screening interviews. Soc Sci Med: 13A; 335-341.

Stimson, G.V., Webb, B. (1975). Going to see the doctor: the consultation process in general practice. London: Routledge.

Stivers, T., Heritage, J. (2001). Breaking the sequential mold: answering 'more than the question' during comprehensive history taking. Text: 21; 151-185.

Street Jr R.L. (1991). Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics. Soc Sci Med: 32; 541-548.

Street Jr R.L. (2002). Gender differences in health care provider-patient communication: are they due to style, stereotypes, or accommodation? Patient Educ Couns: 48; 201-206.

Strull, W.N., Lo, B., Charles, G. (1984). Do patients want to participate in medical decision making? JAMA: 252; 2990-2994.

Suchman, A.L., Markakis, K., Beckman, H.B., Frankel, R. (1997). A model of empathic communication in the medical interview. JAMA: 277; 678-682.

Suchman, A.L., Matthews, D.A. (1988). What makes the patient-doctor relationship therapeutic? Exploring the connexional dimension of medical care. Annals Intern Med: 108; 125-130.

Sue, S., Fujino, D.C., Hu, L., Takeuchi, D.T., Zane. W.S. (1991). Community mental healthy services for ethnic minority groups: a test of the cultural responsiveness hypothesis. J Consulting Clin Psychol: 59; 533-540.

Tabenkin, H., Goodwin, M.A., Zyzanski, S.J., Stange, K.C., Medalie, J.H. (2004).Gender differences in time spent during direct observation of doctor-patient encounters. J Women's Health: 13; 341-349.

Tagliacozzo, D.L. (1965). The nurse from the patient's point of view. In J.K. Skipper Jr, and R.C. Leonard (eds). Social interaction and patient care (pp. 219-228). Philadelphia, PA: Lippincott.

Tannen, D. (1990). You just don't understand. New York: Balantine.

Tate, P. (1983). Doctors' style. In D. Pendleton, and J. Hasler (eds). Doctor-patient communication (pp. 75-85). London: Academic Press.

Taylor, D., Wolfe, R., Cameron, P.A. (2002). Complaints from emergency department patients largely result from treatment and communication problems.

Thornett, A.M. (2001). A comparison between patient consultation satisfaction scores from a trainer and registrar in a Nottinghamshire practice. Br J Gen Pract: 51; 405.

Ting-Toomey, S. (1985). Toward a theory of conflict and culture. In W. Gudykunst, L. Stewart, and S. Ting-Toomey (eds). Communication, culture, and organizational processes (pp. 71-86). Newbury Park, CA: Sage.

Ting-Toomey, S. (1988). A face-negotiation theory. In Y. Kim, and W. Gudykunst (eds). Theory in intercultural communication (pp. 213-238). Newbury Park, CA: Sage.

Tocher, T.M., Larson, E. (1999). Do physicians spend more time with non-English speaking patients? J Gen Intern Med: 14; 303-309.

Todd, K.H., Samaroo, N., Hoffman, J.R. (1993). Ethnicity as a risk factor for inadequate Emergency Department Analgesia. JAMA: 296; 1537-1539.

Triandis, H., Draguns, J. (1980). Handbook of cross-cultural psychology: Vol.6 Psychopathology. Boston: Allyn & Bacon.

Trompenaars, F., Hampden-Turner, C. (1998). Riding the waves of culture: Understanding diversity in global business. New York: McGraw-Hill.

Truax, C, Carkhuff, R. (1967). Toward effective counseling and psychotherapy: training and practice. Chicago: Aldine.

True, R.H., Guillermo, T. (1996). Asian/Pacific Islander American women. In M. Bayne-Smith (ed). Race, gender, and health (pp. 94-120).Thousand Oaks, CA: Sage.

Tuckett, D., Boulton, M., Olsen, C., Williams, A. (1985). Meetings between experts: an approach to sharing ideas in medical consultations. London: Tavistock.

Tuckett, D., Williams, A. (1984). Approaches to the measurement of explanation and information-giving in medical consultations: a review of empirical studies. Soc Sci Med: 18; 571-580.

Turner, B.S. (1988). Medical power and social knowledge. London: Sage.

Turner, S., Maher, E/J., Young, J., Vaughan Hudson, G. (1996). What are the information priorities for cancer patients involved in treatment decisions? An experienced surrogate study in Hodgkin's disease. British J Cancer: 75; 222-227.

Uba, L. (1992). Cultural barriers to health care for South-east refugees. Public Health Rep: 107; 544-548.

Van Den Brick-Muinen, A., De Bakker, D.H., and Bensing, J.M. (1994). Consultations for women's health problems. Br J Gen Pract: 44; 205-210.

Van Den Brick-Muinen, A., Bensing, J.M., Kerssens, J.J. (1998). Gender and communication style in General practice. Differences between women's health care and regular health care. Med Care: 36; 100-106.

Van Den Brick-Muinen, A., Van Dulmen, S., Messerli-Rohrbach, V., Bensing, J. (2002). Do gender-dyads have different communication pattern? A comparative study in Western-European general practices. Patient Educ Couns: 48; 253-264.

Van Ryn, M., Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. Soc Sci Med: 50; 813-828.

Verbrugge, L.M. (1985). Gender and health: an update on hypotheses and evidence. J Health Soc Behav: 26; 156-182.

Waitzkin, H. (1984a). Doctor-patient communication. Clinical implications of social scientific research. JAMA: 252; 2441-2446.

Waitzkin, H. (1984b). The micropolitics of medicine: a contextual analysis. International Journal of Health Services: 14; 339-378.

Waitzkin, H. (1985). Information giving in medical care. J Health Soc Behav: 26; 81-101.

Waitzkin, H. (1991). The politics of medical encounters: how patients and doctors deal with social problems. New Haven: Yale University Press.

Waitzkin, H., Britt, T. (1993). Processing narratives of self-destructive behavior in routine medical encounters: health promotion, disease prevention, and the discourse of health care. Soc Sci Med: 30; 436-449.

Waitzkin, H., Britt, T., Williams, C. (1994). Narratives of aging and social problems in medical encounters with older persons. J Health Soc Behav: 35:322-348.

Waitzkin, H., Cabrera, a., Arroyo de Cabrere, E., Radlow, M., Rodriguez, F. (1996). Patient-doctor communication in cross-national perspective: a study in Mexico. Med Care: 34; 641-671.

Waitzkin, H., Stoeckle, J (1972). The communication of information about illness. Advances in psychosomatic medicine: 8; 180-215.

Wallen, J., Waitzkin, H., Stoeckle, J.D. (1979). Physician stereotypes about female health and illness: a study of patient's sex and the informative process during medical interviews. Women and Health: 4; 135-146.

Warde, C. (2001). Time is of the essence. JGIM: 16; 712-713.

Wardwell, W. (1972). Limited, marginal, and quasi-practitioners. In H. Freeman, S. Levine, and L. Reeder (eds). Handbook of medical sociology (pp. 250-273). Englewood Cliffs: NJ: Prentice Hall.

Ware, J. E. (1978). Effects of acquiescent response set on patient satisfaction ratings. Med Care; 16: 327-336.

Ware, J.E., Hays, R.D. (1988). Methods for measuring patient satisfaction with specific medical encounters. Med Care; 26; 393-402.

Ware, J.E., Snyder, M.K. (1975a). Dimensions of patient attitudes regarding doctors and medical care services. Med Care; 13: 669-682.

Ware, J.E., Snyder, M.K., Wright, W.R. (1976). Development and validation of scales to measure patient satisfaction with health care services: results of scales constructed from the patient satisfaction questionnaire and other health care perceptions (Part B). Carbondale, IL: Southern Illinois University.

Ware, J.E., Snyder, M.K., Wright, W.R., and Davies, A.R. (1983). Defining and measuring patient satisfaction with medical care. Evaluation and Program Planning: 6; 247-263.

Ware, J.E., Wright, W.R., Snyder, M.K., Chu, G.C. (1975b). Consumer perceptions of health care services: implications for academic medicine. J Med Educ: 50: 839-848.

Watson, K., Mahowald, M.B. (1999). Honoring gender-based patient requests for obstetricians: ethical imperative or employment discrimination? J Womens Health Gend Based Med: 8; 1031-1041.

West, C. (1984). Routine complications: troubles with talk between doctors and patients. Bloomington: Indiana University Press.

Weston, W.W., Brown, J.B. (1989). The importance of patients' beliefs. In M. Stewart, and D. Roter (eds). Communicating with medical patients (pp. 77-85). Newbury Park: Sage Pub.

Wheat, M.E., Brownstein, H., Kvitash, V. (1983). Aspects of medical care of Soviet Jewish émigrés. In Cross cultural medicine (special issue). West J Med: 139; 900-904.

White, J., Levinson, W., Roter, D. (1994). "Oh, by the way"...: the closing moments of the medical visit. J Gen Intern Med: 9; 24-28.

White, J., Rosson, C., Christensen, J., Hart, R., Levinson, W. (1997). Wrapping things up: a qualitative analysis of the closing comments of the medical visit. Patient Educ Counc: 30; 155-165.

Wieselberg, H. (1992). Family therapy and ultra-orthodox Jewish families: a structural approach. J Fam Therapy: 14; 305-329.

Wiggers, J.H., Sanson-Fisher, R. (1997). Duration of general practice consultations: association with patient occupational and educational status. Soc Sci Med: 44; 925-934.

Wilkin, D., Metcalfe, D.H.H. (1984). List size and patient contact in general medical practice. BMJ: 289; 1501-1505.

Williams, B. (1994). Patient satisfaction: a valid concept? Soc Sci Med: 38; 509-516.

Williams, S.J., Calnan, M. (1991a). Convergence and divergence: assessing criteria of consumer satisfaction across general practice, dental, and hospital care settings. Soc Sci Med: 33; 707-716.

Williams, S.J., Calnan, M. (1991b). Key determinants of consumer satisfaction with general practice. Fam Pract: 8; 237-242.

Wilson, A. (1985). Consultation length: general practitioners' attitudes and practices. BMJ: 290; 1322-1324.

Wilson, A. (1991). Consultation length in general practice: a review. BMJ: 41; 119- 122.

Winefield, H., Murrell, T., Clifford, J., Farmer, E. (1996). The search for reliable and valid measures of patient centeredness. Psychol Health: 11; 811-824.

Wohl, J. (1989). Integration of cultural awareness into psychotherapy. Am J Psychotherapy: 11; 343-356.

Wolf, M.H., Putnam, S.M., James, S.A., Stiles, W.B. (1978). The medical interview satisfaction scale: development of a scale to measure patient perceptions of physician behavior. J Behav Med: 1; 391-401.

Wolfson, N. (1981). Compliments in cross-cultural perspective. TESOL Quarterly: 15; 117-124.

Woloshin, S., Bickell, N.A., Schwartz, L.M., Gany, F., Welch, G. (1995). Language barriers in medicine in the United States. JAMA: 273; 724-727.

Woloshin, S., Schwartz, L.M., Katz, S.J., Welch, H.G. (1997). Is language a barrier to the use of preventive services ? J Gen Inter Med: 12; 472-477.

Wuest, J. (1991). Harmonising: a North American Indian approach to management of middle ear disease with transcultural nursing implications. J Transcultural Nurs: 3; 5-14.

Yousef, F.S. (1974). Cross-cultural communication: aspects of contrastive social values between North Americans and Middle easterners. Human Organization: 33; 383-387.

Zachariae, R., Pederson, C.G., Jensen A.B., Ehrnrooth, E., Rossen, P.B., von der Maase, H. (2003). Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease. Br J Cancer: 88; 658-665.

Zahr, L.K., Williams, S.G., El-Hadad, A. (1991). Patient satisfaction with nursing care in Alexandria, Egypt. International J Nursing Studies: 28; 337-342.

Zoppi, K.A. (1997). Interviewing as clinical conversation. In M.B. Mengel, and S.A. Fields (eds). Introduction to clinical skills: a patient-centered textbook (pp. 41-55). New York, NY: Plenum Medical Books Com.

Websites:

Israel Central Bureau of Statistics: http://www.cbs.gov.il

Israel Ministry of Health: http://www.health.gov.il

Appendices

Appendix A: Personal Interview Guide

Appendix A1: Personal Interview Guide in Hebrew

ראיון אישי

אני מבקשת לשוחח אתך על הדעות והרגשות שלך בקשר למפגש שלך עם הרופאים שמטפלים בך. דעתך מאד חשובה לי ותתרום למחקר שאני עושה על היחסים בין רופאים ומטופלים.

1. אני מבקשת שתנסה לחשוב על פגישה עם רופא שהיתה לה משמעות מיוחדת עבורך ותספר לי עליה. למה היתה משמעותית? עם איזו תחושה יצאת מהפגישה הזאת עם הרופא? אילו היבטים במפגש הרפואי משמעותיים במיוחד עבורך, איך הרגשת לגביהם במהלך המפגש?

2. מתן מידע וחיפוש מידע

אתה נמצא פה בגלל בעיה רפואית, ואני לא באתי לשאול על המצב הרפואי שלך. אני מבקשת אבל לדעת האם קבלת מידע על הבעיה הרפואית שלך שבגללה אתה פה? ממי קבלת את המידע שיש לך? האם אתה מרגיש שהידע שיש לך על הבעיה הרפואית שלך מספק אותך?
אם קבל את המידע מהרופא המטפל:

- האם הרופא יזם את מתן ההסברים או שאתה שאלת?
- האם המידע של הרופא נתנו סיפק אותך או שרצית לדעת יותר?
- אם רצית לדעת יותר ממה שהרופא הסביר ביוזמתו, האם שאלת אותו?
  אם כן: איך הרופא קבל את השאלות שלך?
  אם לא: למה לא שאלת?
- האם התרשמת שהרופא רואה בנושא של מתן מידע למטופל חלק מתפקידו? (מה גרם להתרשמות שלך)
- האם אתה מבין מה שהרופא הסביר לך?
- האם אתה מרגיש בנוח להגיד לרופא שלא הבנת?

אם קבל ממקורות אחרים:

- מאיזה מקורות קבלת את המידע?
- האם העובדה שנזקקת למקורות שונים אומרת שלא קבלת מספיק מידע מהרופאים?
- האם היית רוצה לחפש עוד מידע? מאיזה מקורות?
- האם אתה מספר לרופא שאתה מחפש מידע נוסף?
  אם לא: למה?
  אם כן: איך הרופא הגיב?

3. קבלת החלטות משותפות

לפעמים מטופלים מספרים על רופא שמשתף את החולה בהחלטה על הטפול הרפואי שהוא צריך לקבל. מה אתה חושב על זה? האם זה נכון גם לגבי הקשר שלך עם הרופא?

מה אתה מבין במונח "לשתף את החולה בהחלטה על הטפול"?

האם אתה חושב שהרופא צריך להיות זה שמחליט על הטפול שלך, או שאתה רוצה שהרופא יציע לך ויתייעץ אתך על דרך הטפול בך?

אם יגיד שלא צריך לשתף: מדוע נכון בעיניך שהרופא יחליט עבורך על הטיפול?

אם יגיד שצריך לשתף: מדוע נכון בעיניך שהחולה יהיה שותף להחלטה על הטיפול?

האם הטפול שאתה מקבל עכשיו הוא החלטה של הרופא שלך? איך התקבלה ההחלטה על הטפול שלך?

לאחר שהרופא הציע לך את דרך הטיפול, האם התייעצת עם עוד מישהו?

עם מי אתה מתייעץ על המצב הרפואי שלך?

4. תקשורת מילולית

האם היו לך אי הבנות בגלל בעיות שפה בפגישות שלך עם רופאים? אם כן, איזה בעיות?

האם הרגשת שהיית רוצה תרגום בפגישה עם הרופא?

האם היה מי שתרגם? מי תרגם? האם היה לך נוח עם מי שתרגם?

האם אתה מוכן שמישהו מהמשפחה שלך יתרגם? הילד שלך? (האם לא נוח לך לספר על בעיות רפואיות בנוכחות הבעל/האשה/הילד?)

5. זמן

יש חולים שמתלוננים שהרופא לא מקדיש להם מספיק זמן, איך אתה מרגיש?

אם המטופל מדווח על חוסר בזמן: איך זה השפיע על המפגש שלך?

מה היית עושה במפגש עם הרופא אילו היה לרופא יותר זמן?

6. תקשורת בינאישית של הרופא

יש חולים שרוצים לדבר עם הרופא רק על הבעיה הרפואית שלהם, ויש חולים שרוצים לספר לרופא גם על ברים אחרים, אישיים.

איך אתה מרגיש? האם אתה חושב הרופא צריך לדעת עליך דברים נוספים חוץ מהבעיה הרפואית שלך? איזה דברים?

האם הרגשת שהרופא רוצה לשמוע על דברים אחרים, אישיים שאתה רוצה לספר לו? האם ספרת?

אם לא: למה לא סיפרת? אם כן: איך זה תרם למפגש?

האם הרופא גם התבדח והיה ידידותי? האם אתה רוצה שהרופא יהיה ידידותי ויתבדח?

7. מגדר

האם אתה מעדיף להיבדק ע"י רופא או רופאה? למה?

מה ההבדל לדעתך בין מפגש עם רופא ומפגש עם רופאה?

עם מי יותר נוח לך לדבר ועל אילו נושאים? האם יש הבדל בין מה שהיית מספר לרופא ולרופאה?

8. סיכום הראיון

איך אתה מדמיין את הקשר האידיאלי בינך כמטופל לבין הרופא?

מה היית רוצה שיהיה אחרת ביחסים שלך עם הרופא שלך? למה?

תודה רבה

Appendix A2: Personal Interview Guide in English

I would like to speak with you about your opinions and feelings concerning your medical encounters with the physicians treating you. Your opinion is very valuable to us, and will contribute to the research we are conducting concerning the relationship between physicians and patients.

1. I ask you to think of an encounter with a physician that had special meaning for you, and tell me about it. Why was it meaningful? With what kind of feelings did you leave the encounter? Which aspects of the encounter were especially meaningful to you, and how did you feel about them during the encounter?

2. Information-giving and information-seeking

You came here because of a medical problem, but it is not the medical problem itself I want to ask you about. I want to know whether you received information concerning your medical condition. Who provided you with this information? Do you feel that the knowledge you possess about your medical problem is sufficient?

If the patient received the information from the treating physician:

- Did the physician initiate the explanations, or did you get the information as a result of your questions?
- Did the physician provide sufficient information, or did you want to know more?
- If you wanted to know more than the physician initiated, did you ask him/her?
  If yes: how did the physician accept your questions?
  If no: why did you not ask?
- Did you feel that the physician sees the issue of information giving as part of his duty? What gave you this impression?
- Do you understand what the physician told you?
- Do you feel comfortable telling the physician when you do not understand?

If the patient received information from other sources:

- From which sources did you get the information?
- Does the fact that you used other sources mean that you have not received enough information from your physician?
- Would you like to search for more information? From which sources?
- Have you told your physician that you are looking for more information?
  If not: why?
  If yes: how did the physician react?

3. Participatory decision-making

Patients sometimes tell about physicians who let their patients participate in decisions about their medical treatment. How do you feel about this issue? Is this true about your relationship with your physician?

How do you understand the term "to participate in the decision regarding your treatment"?

Do you think that the physician should decide about your treatment? Do you want the physician to make suggestions and consult you about your treatment?

If the patient does not want to participate: Why do you think it is right for the physician to make decisions about your treatment?

If the patient wants to participate: Why do you think it is right for the patient to participate in the decision about his/her treatment?

Is the treatment you are receiving now a result of your physician's decision? How did you and the physician come to the decision?

Did you consult someone else after the physician suggested your treatment?

Who do you consult with regarding your medical decisions?

4. Verbal communication

Did you have any misunderstandings due to language problems in your medical encounters with physicians? What sort of problems?

Did you feel that you would have liked to receive a translation during the encounter?

Did you get a translation? By whom? Were you comfortable with the person who translated?

Do you want your family member to translate? Would you want your child to translate? Are you uncomfortable talking about medical problems in the presence of your husband/ wife/ child?

5. Time

Some patients complain that their physicians do not dedicate enough time to their encounters. How do you feel on this issue?

If the patient reports lack of time: How did this affect your visit?

What would you do in a visit with your physician, if he/she had more time?

6. Physician's interpersonal communication

Some patients want to speak to their physician about their medical problems only, while others want to tell their physician about other issues, including personal issues.

How do you feel? Do you think your physician should know more things about you, other than your medical problem? What sort of things?

Do you feel that your physician wants to hear about personal issues that you want to tell him/her about? Did you tell?

If not: why did you not tell?

If yes: how did telling contribute to the encounter?

Was the physician friendly? Did he tell any jokes? Do you want your physician to be friendly, to tell jokes?

7. Gender

Would you rather be examined by a male or female physician? Why?

What is the difference, in your opinion, between an encounter with a male physician and an encounter with a female physician?

Who do you feel more comfortable talking to, and about what issues? Is there a difference in what you would tell a male physician or a female physician?

8. Summary of the Interview

How do you imagine the ideal relations between yourself as a patient and your physician?

What would you like to be different in your relations with your physician?

Thank you very much.

Appendix B: In-depth interviews - Analysis

1.1 Patient Recall of Past Medical Encounters

When recalling encounters and relations with physicians, all thirty patients mentioned three categories: personal relations; information-giving and question-answering; and time dedicated by the physician. These categories were not suggested by the interviewer and emerged as the main features valued by patients when visiting their physicians. Although eight patients had no special memories of their medical encounters, eight spoke of positive feelings, and fifteen reported on visits that aroused negative feelings.

1.1.1 Jewish-Israeli patients

Among the ten Jewish-Israeli (JI) patients, two females did not recall any special medical encounter, two males and two females recalled positive encounters, and four males remembered negative visits. One female reported two encounters that left both positive and negative impressions.

Positive Encounters

Personal relations: All ten JI patients spoke of *"pleasant and patient"* physicians, and felt that this attitude contributed to *"better communication"* and to a feeling of *"faith and trust in my physician"*. One patient compared the way physicians treat patients nowadays to physician-patient relations *"in the sixties"*, when doctors looked down on him and were unfriendly. Presently physicians' attitudes have improved, and their personal relations are *"courteous and caring"*.

Information-giving and question-answering: All ten JI patients spoke of physicians who *"gave me all the information I wanted to know"*, who *"explain everything, including the risks and success rates"*, and who *"give all the details and with a lot of patience"*. Patients reported that this approach made them *"respect the physician who does his job well"*, and provided *"a feeling of confidence and trust in this physician"*. These patients all remembered that the physicians answered their questions willingly, thus enabling them to respect the physician, giving them a positive feeling, and contributing to better communication.

Time offered by the physician: Patients were very concerned with the issue of time spent with the physician. They spoke of *"a physician who was not in a hurry"*, and who had given the patient all the time needed to understand the medical problem and to ask all his questions. A female patient reported a case where *"I had many problems, and the physician dedicated a lot*

of time and attention, which was exceptional in comparison with other doctors, and made me feel confident with what he said". She also felt the time spent with this physician contributed to better communication and enabled her to participate in decisions about her treatment.

Negative encounters

Personal relations: Four male and one female JI patients mentioned physicians who had left them with *"a bad feeling", "with anger, frustration and stress".* Some even changed physicians. Descriptions of their experience included: *"the physician spoke in a cold voice, she was aggressive and harsh, which made me cry"* and *"the physician treated me as a medical specimen and not as a patient and a human being, and he did not address my suffering".*

Information-giving and question-answering: Both lack of information and physician's reluctance to answer questions were reported to give a bad and unpleasant feeling, and to breach patient trust in the physician *"because he does not care about you".* Patients mentioned physicians who did not provide any specific information and did not go into details about medical problems. Patients reported that physicians refused to answer their questions, *"did not react to my questions and chose to ignore them",* and *"gave me the feeling that I am not supposed to ask any questions, as if my questions show disrespect to the doctor's authority".* One patient said that *"it is part of the doctor's profession and his duty to answer the patient's questions",* and when his physician neglected to do so, he felt *"stressed and hurt".*

Time dedicated by the physician: Three JI patients reported that their physicians were short of time and impatient. One patient said:*" The physician spent so little time with me that he did not even examine me".* These patients felt that lack of time prevented them from asking questions and from understanding their medical problems, and created a bad atmosphere. One was so frustrated and angry he asked to be transferred to a different physician.

1.1.2 Arab-Israeli patients

Two male and one female Arab-Israeli (AI) patients did not report any special encounters with their physicians. One male and two females remembered positive encounters, while four male and two female patients recalled encounters that left them with negative emotions.

Positive encounters

Personal relations: One male and two female AI patients remembered *"a pleasant and patient physician"* who *"makes you feel comfortable",* and *"speaking to him is like speaking to a friend or family member".* One female reported that her Arabic-speaking family physician *"treats me with a personal touch, and I consult him about personal issues".*

Information-giving and question-answering: One male and two female AI patients mentioned information-giving as a factor influencing their trust in the physician and improving their feelings about the encounter. They spoke of *"a physician with great knowledge, who explained everything I wanted to know", "who volunteered a lot of information, which made us share a common language, and made me feel that the doctor treated me like a friend".*

Time dedicated by the physician: One female spoke of her Arabic-speaking family physician, who always dedicates a lot of time to their encounters, so that she can speak about whatever she wants, including personal issues. She felt that Hebrew-speaking physicians tend to spend less time with her, even with a translator. Another female remembered an exceptional physician who took all the time needed until she fully understood everything, and she admired his patience and devotion.

Negative encounters

Personal relations: All AI patients who reported on negative memories addressed the issue of personal relations with great intensity and frustration. They used expressions such as: *"The doctor was very professional, but suffered from lack of communication"*, and *"he was hard-hearted and inconsiderate with my needs and complaints"*. Two male patients felt their physicians *"did not take any interest in me as a human being, belittled my needs and did not take me seriously"*. These patients felt angry, hurt, frustrated and disappointed.

Information-giving and question-answering: Six AI patients reporting a lack of sufficient information and reluctance among physicians to answer their questions. This created mistrust, anger and a negative atmosphere. One female patient said: *"I did not understand my medical problem at all, and I did not feel that I could ask what I wanted to know, because the doctor was impatient and did not want to answer".*

Time dedicated by the physician: Two male and one female AI patients commented on shortage of time. One male patient said that all physicians suffer from lack of time, and that he had never met with a physician who had spent enough time with him. Another male patient remembered a physician who came late to the clinic. Once the patient came into the room, the physician was so impatient and short of time that he neglected to examine him, was not willing to answer his questions, and the patient got up and walked out of the room without any information or treatment. All patients said that lack of time creates a tense atmosphere, and prevents them from asking questions and fully understanding their medical problems.

1.1.3 Immigrant patients from the FSU

Two male and one female FSU immigrant patients did not recall a special encounter. One female patient reported visits that had left her with positive memories, and five patients, one male and four females, remembered encounters that left negative feelings.

Positive encounters

One female patient compared the physicians in her home country to the Israeli physician she had met. She claimed that in Tadgikistan physicians were not as well equipped, *but "they were warm-hearted, had a good heart and cared more about their patients"*. She reported that her treating physicians in Tadgikistan were friendly and kind, and open to long conversations. She remembered in particular one physician who gave her detailed information about her medical problems and suggested and explained different treatment options. When visiting this physician, she felt free to ask anything she wanted to know, and he always had the time and patience to answer.

Negative encounters

Personal relations: All five FSU immigrant patients who remembered negative encounters reported on physicians who "were not humane". One patient said, *"The physician acted like a machine, not like a person, his relations were not humane, unlike the physicians in Russia, where every physician was like a psychologist too"*. He said that in Russia his physician wanted to know about his concerns, his family members and relations in the family, and he felt that this physician really cared about his well being. In contrast, he felt that physicians in Israel are *"not interested in the person who is sitting in front of them and in his suffering"*. Another patient complained that the physician did not take her complaints seriously and belittled her suffering and pain. These patients used the term *"ben adam"* or the equivalent Yiddish expression *"mensch"*, meaning a "human being", which in this context denotes being humane, having a devoted and caring attitude. All these patients felt hurt and insulted by such an unkind attitude, and reported that it lead to a feeling of mistrust with their physicians.

Information-giving and question-answering: All five patients felt they had not received sufficient information from their physicians. Three attributed this to language barriers with Israeli physicians. They said: *"It is difficult to ask Israeli doctors many questions, because I cannot make myself understood in Hebrew, and they do not understand what I want to know"*. One patient felt *"the physician was not listening to me seriously, and he did not consider my questions as important"*.

Time dedicated by the physician: One male and three female FSU immigrant patients thought the physicians were short of time and did not spend enough time with them. They all spoke of their difficulties in speaking Hebrew with these physicians, and noted that more time with the physicians would have enabled them to ask more questions so they could better understand their medical problems. One female patient remembered a physician who asked her:" *Why are you coming again? I spent enough time with you last time, and you are receiving all the medication which you need. I have no time for you*". This patient was very hurt, and asked to be transferred to a different physician. Other patients said:" *Physicians have no time. They are trying, but they are too busy and they lack time*". These patients felt they needed to spend more time with their physicians to better understand their medical problems and treatment. They also wanted to ask more questions, and to speak of their concerns and other personal issues, but did not have the time to do so. They reported that shortage of time had a negative effect on the atmosphere of the encounter.

1.2 Information-Giving and Information-Seeking

1.2.1 Who provided patients with medical information, and did they understand it?

Of the thirty patients, eighteen received information concerning their medical problems directly from the treating physician, and twelve consulted their treating physician as well as seeking a second opinion. Although two patients felt they did not understand the information received, the other 28 patients reported they understood the information.

Jewish-Israeli patients: Five males and three females received their information from their treating physician. The other two males consulted another physician as well. One female patient felt that *"I know next to nothing about my medical problem because the physician did not go into any details about the medical problem and the medical procedures"*. The other nine patients said they understood their physicians' explanations.

Arab-Israeli patients: Four males and three females received information from their treating physician. Three patients, two males and one female, consulted both the treating physician and their Arabic-speaking family physician. One female patient reported she understood the information given by the physician, but as it was partial and insufficient, she felt she did not understand enough about her medical problem and treatment.

Immigrant patients from the FSU: Two males and one female received medical information from their treating physician only. Seven patients, two males and five females, received their medical information from both their treating physician and their Russian-speaking family physician. One male and three female patients felt they were able to understand the information

because they also consulted their Russian-speaking family physician. One male patient said he was able to understand the information *"in a superficial way, because I am not a physician and I do not understand specific details"*.

1.2.2 Was the information sufficient?

Nineteen patients reported they received sufficient information concerning their medical problem, while eleven claimed to have received insufficient information. Half the patients (15) expressed no desire for more information, while the other half wanted more information about their medical problem.

Jewish-Israeli patients: Seven JI patients, five males and two females, said the information they received from their physician was sufficient. Three patients, one male and two females, claimed the information was insufficient. Another five patients, four males and one female, did not want to seek more information, claiming they trusted their physician and his medical knowledge. One expression was: *"I trust my doctor that he has the knowledge and he is excellent, and I do not need any other sources"*. Finally, five patients, two males and three females, wanted to receive more information regarding their medical problem.

Arab-Israeli patients: Nine of the ten AI patients, six males and three females, reported on sufficient information concerning their medical problem, while one female patient said the information was insufficient. Seven AI patients, four males and three females, did not want to receive more information because they trusted their physicians to have all the necessary knowledge and information. Three patients, two males and one female, wanted more information.

Immigrant patients from the FSU: Three FSU immigrant patients, one male and two females, reported they received sufficient information. Seven patients, three males and four females, were not satisfied with the amount of information they received concerning their medical problem. Three patients, one male and three females, did not want more information because they trusted their doctors' knowledge. Finally, the same seven patients, three males and four females, who claimed to have received insufficient information from their physician reported wanting additional information concerning their medical problem.

1.2.3 Sources of additional information

The patients who said they sought further information gained this information from a variety of sources. Twelve spoke with family members about their medical problem and shared the information they had received from their physicians. These patients did not expect to gain

further knowledge about their medical problem from their relatives, and considered it more as "a family conversation", a means of sharing and receiving support from family members. Three patients spoke with friends yet did not expect them to provide more information, and one FSU immigrant patient spoke to a friend with a similar medical problem. Five patients searched for further information in medical books, medical encyclopaedias and medical publications, while two patients spoke with patients with similar medical problems. Although seven patients tried to search for information on the Internet, they all claimed they could not find valuable information. Finally, two patients consulted other specialist physicians.

Jewish-Israeli patients: Two male JI patients spoke to their family about the information they received from the physician. They reported they did not expect family members to add to their knowledge, but rather spoke to them because they wanted to inform their family of the problem, *"I tell my children what the doctor said, but I trust the doctor, because they are not doctors"*. One male patient who reported having sufficient information and did not want to search for more information also reported speaking with his children about his medical problem.

One male patient spoke to his friends about his medical problem but did not expect them to provide more information. Two males and three females searched the Internet for medical information, while two said the amount of information found on the Internet is so extensive that it is difficult to decide what is applicable. One male and one female read medical books, a medical encyclopaedia, and medical publications concerning their medical problem. They read about innovations, new treatments and new medications. One male patient consulted another specialist for additional information, and one female patient consulted a physician friend.

Arab-Israeli patients: Five male and one female AI patients who stated the information they received from their physicians was sufficient and said they were not looking for more information, reported telling their family members about their information. They all claimed they are not looking for further information from their relatives, *"because they are not physicians and they do not know medicine"*, but rather that they want their family members to know about their medical problems so they can discuss these problems with them. One male and one female spoke about their medical problem with friends, but not in order to gain more information. They did not expect their friends to have medical information. One male patient consulted two friends who are both physicians. Another male patient spoke with other patients with similar medical problems, and one female patient searched the Internet, but could not find any useful information.

Immigrant patients from the FSU: Two female and one male FSU immigrant patients spoke to family members about their medical problem, but did not expect them to provide additional

information. However, two female patients did receive information from friends who suffered from similar medical problems. Two females and one male stated they would like to gain more information, but do not know where to look for it. One female patient reported reading books on alternative medicine, and one male patient searched for information in a medical encyclopaedia. One male patient tried to search the Internet, and one male patient consulted friends who are physicians.

1.2.4 Do patients tell their physician that they seek additional information?

Fifteen patients expressed a desire to find information from additional sources. However, only ten patients expanded on this question, while the others were reluctant to answer. Five of these ten told their treating physicians about the information they received, while five did not reveal they had sought further information.

Jewish-Israeli patients: Two JI patients, one male and one female, did not tell their treating physicians they were seeking additional information because they did not want to insult him/her. Three patients, two male and one female, did tell their physician they were getting more information. Their feelings were that *"my physician was glad to hear about innovations I have read about, and she was happy that I am interested and that I want to learn more about my medical problem and treatment"*. Two other patients said they told their physicians what they learned from other sources, and asked their physicians questions about the new information. Their physicians accepted these questions willingly.

Arab-Israeli patients: One AI female patient said she did not tell her physician about further information she had received because she felt uncomfortable telling him and thus causing him to think his authority had been breached. She also did not spend enough time with the physician to be able to tell him her concerns. One male patient told his physician about his readings in alternative medicine and said that *"the physician laughed and was not offended"*.

Immigrant patients from the FSU: Among FSU immigrant patients, one male and one female reported that they do not tell their physician about seeking further information, because *"I am shy and I feel uncomfortable about telling"*, and because *"I don't want him to think that I criticize his knowledge"*. One male patient who read a medical encyclopaedia in Russian told his physician about the information and asked questions about it.

1.2.5 Questions asked by the patient

Twenty-seven patients reported asking their treating physicians questions during the encounter.

Jewish-Israeli patients: All ten JI patients, four males and six females, reported asking their physicians questions concerning their medical problem and treatment. Five males and one female said they asked about everything they wanted to know. One male and two females felt comfortable asking questions *"because as a patient I need to get a lot of* information*"* and *"because it is always good to know more and I want to understand"*. One patient said he generally prepares a list of questions at home in order not to forget to ask the physician everything he wants to know. A female patient explained that *"it is the duty of the physician to explain and to answer, and it is my right to ask questions. It is my health and I want to know"*.

One female patient reported that she does not ask a lot of questions because she feels physicians are too busy. Another female patient said that she asks questions but feels as if she is doing something that is not right *"as if the physician is thinking- I have many more patients to see, what do you think, that you are alone here?"* Another male patient said that physicians are mostly very busy and therefore cannot answer many questions. That is why he generally does not ask all the questions he would like to ask, and it embarrasses him to ask many questions.

Arab-Israeli patients: One AI female patient reported that she felt she could not ask whatever she wanted because the physician looked down on her and was too impatient. This made her feel uncomfortable and angry. She said it was the physician's duty to explain and answer questions, but that in the past when she did ask her physician, he was reluctant to answer. The other nine patients, six males and three females, reported asking their treating physicians questions. Seven patients, five males and two females, said they are not shy about asking questions, and that they all received answers. One of the expressions used was: *To ask questions and to find out things before taking an important step is the patient's right"*.

Three males and one female said they only asked a few questions, because *"the information given was sufficient and there was no need for more information"*. One male patient said he only asks questions about *"what I think is really important, because physicians do not have the time to listen to endless questions, and one should not disturb them because they are very busy"*. One female patient who did not speak Hebrew well asked most of her questions when she visited her Arabic-speaking family physician. *"When my physician does not speak Arabic, it is difficult to ask, even with a translator present, it is not the same as with my physician"*. She added that her bilingual relatives are the ones who ask her JI treating physician most of the questions.

Immigrant patients from the FSU: Among FSU immigrant patients, one male and one female did not ask their treating physician questions because *"it never occurred to me to ask and the physician is the authority"*. The female said she is shy, and she does not like to ask questions,

but her husband mostly asks the physician questions. Whenever her husband was present in the meeting with the physician she also asked the physician some questions. The other eight FSU immigrant patients stated they asked questions during their encounters.

Five patients, two males and three females, only asked their treating physician a few selected questions. The expressions they used were, *"It is not so pleasant to ask", "I do not understand much about medicine so I only ask little"* and *"I only ask when I feel I don't understand and when it is important to know something"*. Two female patients hardly asked any questions because they found it difficult to explain themselves in Hebrew. *"When I see a Russian speaking physician I ask more"*. One male and one female felt that physicians are short of time, and therefore they only ask questions when they feel the physician has time to answer. Only one male patient stated he was able to ask about everything he wanted to know.

1.2.6 Physicians' attitude toward patients' questions

Of the thirty patients, only four female patients felt their physicians did not accept their questions willingly. The other 26 patients reported that their physicians answered their questions willingly.

Jewish-Israeli patients: Two female JI patients thought their physicians were reluctant to answer questions, and therefore they felt they lacked sufficient information. Another patient said: *"I am not sure that the physician understands that it is his duty to give the patient information and to answer questions"*. The remaining eight JI patients, six males and two females, felt their physicians considered question-answering part of their duty. Their expressions were: *The physician accepted my questions willingly, he answered with patience, in a friendly and detailed manner"*, and *"the physician was attentive to my questions, and answered patiently, in a sincere and truthful manner"*.

Arab-Israeli patients: One female AI patient reported feeling uncomfortable about asking her physician questions *"because of his attitude, because when I do ask the questions, I feel he does not want to answer"*. She disagreed and stated: *"I think it is the physician's duty to his patients to answer and explain everything"*. The other nine Arab-Israeli patients, six males and three females, felt their physicians accepted all their questions willingly. Their expressions were: *"I always feel my physician takes the time to answer my questions" and "my physician answers all my questions cordially, in detail and patiently"*.

Immigrant patients from the FSU: One female patient was not satisfied with her physician's attitude when she asked questions. She said: *"I feel he does not take the time, he does not want to spend more time with me in order to answer my questions"*. Three males and five females felt

their physicians answered questions willingly and in a friendly way. *"Sometimes I am stressed and I ask questions nervously, and still the physician always answers nicely"* and *"the physician answered all my questions cordially and gave me detailed information"*.

1.3 Participatory Decision-Making (PDM)

1.3.1 Who should decide about patient treatment?

Nineteen patients felt the decision concerning their treatment should be left to their physician. Four patients, however, felt they themselves would want to make that decision after hearing the physicians' recommendations. The remaining seven patients wanted to share the decision with their physicians and to be part of the decision-making (DM) process.

Jewish-Israeli patients: Four male and one female JI patients thought the physician should be the one to decide about their treatment. They said: *"The physician has the knowledge and the authority, and one should leave the decisions in his hands. What the doctor thinks is the right thing to do; this is what should be done"*. Another patient said: *"He studied medicine, and I am not experienced and know nothing about it. Only he understands and knows every medication. He will know where it will go to in my body, and I accept his opinion and advice in everything"*. Another expression was: *"This is what they are learning for, and I know nothing about it. It is not my field"*.

Two male and three female JI patients believed the physician and the patient should be partners in making treatment decisions. They felt the physician has the information and knowledge, yet they want to share the decision with him *"because it is my body and my life, and I have to be part of the decision, which affects whatever is happening with me"*. Another patient said: *"The doctor has to share the options with the patient, and explain his reasoning for the recommended choice. Then the patient feels that he was part of the decision and that he can share the decision with the physician"*. A male patient said: *"It is my body, it is my decision, but I can only make it in collaboration with the physician's advice and together with him"*. He added: *"It is my body, and I know best what is happening to me and how I feel, therefore my opinion should be taken into consideration. I want to be a partner in the decision concerning what is happening to me"*.

Arab-Israeli patients: Three male and three female AI patients wanted to leave treatment decisions to the physician. They said: *"The physician is the one who knows, he understands because he studied"*. *"He has the knowledge, he studied, he has the authority to decide"*. Four male patients said they trusted the physicians to take the right decisions, and one of them said: *"I make the doctor responsible for my health, I do not* want *to be part of the decision of my treatment"*.

One male and one female AI patient thought the patient should decide about his or her treatment. The male said: *"The physician has the medical know-how, but this is my life, my body and therefore the final decision is in my hands and not in the physician's"*. He added: *"I examine the alternatives which the physician offers, and I decide which I prefer. I tell the physician what my preference is, and I expect the physician to accept my decision"*. The female said: *"The physician should give the patient all the information and options, and recommend to the patient what he thinks should be done. But the decision is mine. I need to decide what is good for me, and which treatment is right for my body"*.

Two male patients felt they should participate in the decision and decide *"together with the physician"*. One patient said: *"The physician directs me to the right thing to do, I need to decide with him, and he has to help me decide what is right for me"*. The other patient reported: *"I want to know everything from the physician, and then I feel that I can trust him, and that he is a good physician. I share my opinion with him, and then I feel that I can do what we both think is the best thing to do"*.

Immigrant patients from the FSU: Three male and five female FSU immigrant patients believed that the decision about their treatment should be left to the physician. They said: *"I do not know enough about medicine to be involved in the decision"*, and *"this is his profession, and he has the knowledge"*. They all said they trusted their physician to make the right decisions, and one patient added: *"It is easier when the physician takes the responsibility"*. One male patient said that the *"ideal case"* would be for the patient and the physician to take decisions together, *"as partners, but in reality this is impossible. I do not know enough about medicine, and I cannot make decisions"*.

Among the FSU immigrant patients, one male and one female said they should be the ones to decide about their treatment. The male patient said: *"The physician explained the options, and the results of each option. I want to consult the physician and to understand what he thinks, and his opinion is very important, but I have to decide. I don't want to cast the responsibility on the physician. I need to take the decision about my health"*. The female patient thought that *"the physician should explain exactly what the problem is, and what should be done, and according to this information, I should decide to do what I want and what I feel is right. Physicians do not force me to do something. The physician explains it and tells me, we shall do whatever you want and in any way that you want"*.

1.3.2 Who made the decision regarding patient treatment?

Nineteen out of thirty patients wanted the physicians to make decisions about their treatment. Four patients wanted to take responsibility for the decisions themselves, while seven wanted to take an active role in the DM procedure regarding their medical treatment.

Jewish-Israeli patients: Four males and one female reported it was the physician who decided on their medical treatment. All five said that their physicians had not offered mutuality in the DM process, and that they had not expressed any desire for such mutuality. They felt they did not have the medical knowledge, and said: *"It is his profession, and not mine, and therefore he should decide. I trust him and his know-how"*. One patient said: *"This is not my field. I would not want anybody in my work to interfere with what I know more about"*. They all agreed that they trust their physicians, and *"respect him and his expertise"*.

Two males and three females reported sharing the decisions with their physicians. Their physicians suggested PDM, and they all agreed this was the right thing to do. One female patient said: *"I hear what the physician says, and I tell him what I feel, and although his opinion is more important, I want him to consider mine. I feel that we decided together on what is best for me"*. Another patient said: *"It is important for me to participate in understanding the information, and in making the decisions, because it is my life and my body. I want to be part of the decisions that concern me. I got the feeling that I share the procedure, that my feelings count, and this is more pleasant than* when *the physician decides by himself*".

Arab-Israeli patients: Three male and three female AI patients reported that their physicians made the decisions about their treatment. They all thought they wanted the physicians to decide, and they did not want to be involved in the decisions because they lack the medical know how. These six AI patients reported that their physicians had not suggested PDM, and that they had no desire to request it. Their arguments were: *"The physician made the decision, and if he would have asked me, I would have let him decide, because of his knowledge"*, and *"the decision is in the hands of the physician who knows best what the right treatment is"*. One female patient said: *"The physician decides what treatment to give, and God decides what will happen to the person"*.

One male and one female said they made their own decisions and their physician complied with their choices. The male informed his physician about his preferences after the physician had suggested mutual DM. He heard all the options, decided which he preferred, and the physician accepted his choice. He considered this procedure his choice, because he did not choose the physician's first choice, and he was satisfied that the physician did not oppose his decision. The

female patient reported that the medical decision should be hers, and that *"I should know what is good for me"*. Her physician suggested an operation, and she did not want to undergo surgery. She wanted *"to decide about the treatment for my body"*, and she refused surgery. She complained that the physician gave her the feeling she had shown disrespect for his authority, and that this made her nervous. She felt it was her right to decide what was best for her.

Two male patients whose physicians had suggested mutual DM felt they shared in the procedure with their physicians. They both felt that the physicians have authority and knowledge, that they had confidence in them, but that the physician should not decide alone. *"He should not make the decision for me. I want him to share his considerations with me. I feel that he guides me to the right decision, and then I feel safe that it is the right thing to do. I ask him, if you were in my place, what would you do? And his answer directs me as to whether to accept his opinion"*.

Immigrant patients from the FSU: All eight FSU immigrant patients, three males and five females, who thought the physician should make the medical decision stated that they, indeed, left these decisions to their physician. A female patient said: *"I did not wish to be part of the decisions. I wanted the physician to explain what he intended to do, which he did, yet he should be the one to decide"*. Two male patients said that *"the treatment is the decision of the physician, and this is right. This is how it should be"* and, *"I have no medical knowledge, I cannot decide. Therefore I have to believe in my physician and let him decide"*.

The physicians of two FSU immigrant patients, one male and one female, offered to share treatment decisions with them, yet both reported that that in their opinion the patients should decide for themselves. The male patient said: *"I need to understand what the physician thinks and I need to decide what I feel concerning my health. I do not want to cast the responsibility on my physician. I have to take this responsibility over my health"*. The female patient said: *"The decision has to be according to what the physician explains and to what I feel, and then I have to decide. And this is how it was"*.

1.3.3 Who is consulted regarding treatment?

Fourteen of the thirty patients did not consult other sources after meeting with their physician, while sixteen did consult several other sources.

Jewish-Israeli patients: Three male and one female JI patients did not consult other sources after having visited their physician. They did not feel they needed more advice and were satisfied with the physician's decisions. Two males told their family members and friends about the physician's recommendations, but felt this was not a consultation, but rather a sharing of their problems with family and friends. Since they did not think their relatives and friends

possessed the medical knowledge to advise them, they considered these to be personal conversations.

Three male and three female JI patients claimed they consulted additional sources. Two males and one female consulted family members, including parents, spouses and children. Two males and one female met with friends or relatives who are physicians to consult with them. One male and one female read medical books and publications about their medical problems and about treatment, and two females searched the Internet. One female patient consulted her family physician about the treating physician's recommendation, three patients mentioned consultations with a rabbi, and one patient said she did not really think the rabbi was knowledgeable in medical problems but that her mother had insisted. Another patient said that his wife consulted a rabbi to get his advice and his prayers for the success of his operation. The third patient was still considering whether he should meet with the rabbi. He said: *"Many people go to the rabbi like to a psychologist, for spiritual support"*.

Arab-Israeli patients: Four male and two female AI patients did not feel the need to consult other sources after visiting their physician. Five males and three females told their family members about the consultation and the physician's recommendations. They all said their family members did not interfere in the physician's considerations. None of these AI patients consulted a sheikh or a priest. They said: *"The priest is in the religion and the physician in the medicine"*, and, *"You see the priest for your soul, for prayers. God decides what will be and the priest does not know about medicine"*. Another patient said: *"You go to the sheikh to pray for the success of an operation, but not for medical decisions"*.

Two male and two female AI patients consulted additional sources after seeing their physician. One male and one female visited their Arabic-speaking family physician. Two male patients consulted a friend and a brother who are physicians. Two male and one female discussed the physicians' recommendations with family members. One female patient consulted her friends, and one male patient consulted some alternative medicine publications.

Immigrant patients from the FSU: Two male and one female FSU immigrant patients did not consult other sources. They said they trusted the physician's decisions and they would not know with whom else they could consult. Two males and five females felt the need to consult other sources. These patients turned to their Russian-speaking family physicians for consultations. One female consulted another patient who suffered from a similar medical problem. One male met friends who are physicians. Two males and four females consulted family members and relatives about the physicians' recommendations. One male and one female consulted their friends. One female patient saw a rabbi, *"because it is important to get hope"*, and three male

patients said they knew people who turn to a rabbi but they themselves did not go because *"it is not his profession. A cleric is not a physician"*.

1.4 Verbal communication

1.4.1 Did patients have language difficulties during meetings with their physician?

Nine of the thirty patients suffered from language difficulties, while twenty-one did not.

Jewish-Israeli patients: Five male and four female JI patients reported having no problems when meeting with Arab-Israeli and with FSU immigrant physicians. One male patient reported having language difficulties with young FSU immigrant physicians. He said: *"I don't mind being examined by them, but the communication with them is difficult. The language difficulties project onto their humane attitude, and did not help to create a positive interaction with them"*. He did not think the language barrier influenced the medical care, but emphasized that it affected the atmosphere. This patient also complained about physicians speaking Russian among themselves in his presence when discussing his medical problems. *"I want to know what they are saying about me, and when I don't understand their language, I get anxious"*.

Arab-Israeli patients: Among the AI patients, seven males and one female had no problems communicating with their physicians, including their Hebrew-speaking physicians. A male patient said: *"I have a good knowledge of the Hebrew language, and I understand everything. With my family physician I speak Arabic, but here I speak Hebrew and it creates no problems"*. Three female patients reported having had language difficulties with Hebrew-speaking physicians. They all relied on accompanying relatives, who translated for them during the visits. One male AI patient commented on Russian-speaking physicians who have the habit of speaking Russian in his presence. *"It makes me feel they are ignoring me, and it bothers me that I don't understand what they are saying about me"*. Five males and three females mentioned their Arabic-speaking family physicians. One female patient said: *"It is easier to see an Arabic-speaking physician, because I can make myself better understood"*. Another female patient said: *"I hardly speak Hebrew, so I try to go to physicians who speak Arabic"*.

Immigrant patients from the FSU: One male and two female FSU immigrant patients reported having language difficulties shortly after their immigration to Israel. *"When I just arrived in the country, it was very difficult to visit an Israeli physician, because I did not understand the language or what I was told"*. These patients no longer felt they have any language problems. Two males and two females did not have language difficulties because their physicians were Russian-speaking. They reported having difficulties understanding Hebrew-speaking

physicians, and they tried to speak English or Yiddish with the physicians or to ask for interpretation.

Three male and four female FSU immigrant patients reported having language difficulties when meeting with Hebrew-speaking physicians. A female patient said: *"I don't understand what the physician says, and I don't get enough information about my problem and about my treatment. It makes me feel stressed"*. Another female patient said: *"I didn't understand what he said, and I couldn't explain what I wanted to tell him"*. A male patient felt that with a Hebrew speaking physician *"I can't speak of all the details and nuances which I can tell a Russian speaking physician"*. All these patients preferred meeting with Russian-speaking physicians, enabling them to better understand medical information and ask more questions.

1.4.2 Translation during the medical encounter: Who translated?

Translators assisted eleven AI and FSU immigrant patients.

Arab-Israeli patients: Three female AI patients felt the need for translation. They all said they did not speak Hebrew well, and had difficulties in understanding what their Hebrew-speaking physicians said. One patient said: *"When I meet with an Israeli physician who does not speak Arabic, my husband translates for me, and sometimes a nurse or an Arabic-speaking physician joins the Israeli physician"*. Another patient reported that a family member always escorts her to encounters with physicians who do not speak Arabic. One male patient did not have any problems understanding Jewish-Israeli physicians, but did have difficulties with FSU immigrant physicians who did not speak Hebrew well. He reported that a nurse translated during the encounters.

Immigrant patients from the FSU: One male and two female patients did not use interpreters. The male patient did not feel it was necessary, while the two female patients were unable to find anybody who could translate. One of them was not sure if she wanted assistance, *"because the translation cuts off the direct connection between the physician and me"*. Three male and four female patients had help in translation from various sources, including Russian-speaking medical staff, nurses, physicians and medical secretaries, as well as family members such as husbands, wives and children. Such family member-translators accompanied two males and four females. One male patient came with a friend, and a female patient asked another patient to assist her.

1.4.3 Patient preferences regarding interpreters

Eleven patients had no preferences as to who translated for them, but some were shy in front of their family members. One patient did not want her son to translate for her.

Arab-Israeli patients: Two male and two female AI patients did not mind who the interpreter was. A female patient said: *"It does not bother me who translates, medical staff, my family. A family member is even better. For the secrets of the body it is better to have the translation by someone from the family and not by a stranger"*. She did not mind if her children translated, *"because children nowadays know everything anyhow"*. All these patients did not mind if their family members translated for them and were not embarrassed by the presence and translation of their children. A female patient emphasized: *"I don't care who translates, my husband, a nurse, because I want to understand"*.

Immigrant patients from the FSU: Three male and three female patients did not mind who the translator was, because *"the important thing is to understand the physician"*. A female patient said: *"I ask everybody for assistance, a nurse, a Russian physician, my daughters, because lack of information is a fundamental problem"*. Another female patient felt: *"It is important to find someone to translate, no matter whom, because it is not good to not understand"*. This patient did not mind if her daughter translated. *"I don't feel shy, because my daughter is like my friend"*. A male patient thought it was best when his wife or son translated, *"because they are aware of my problems, as I tell them about it anyhow, and I consult them"*.

Two female patients did not feel comfortable asking their sons to translate. One patient did not mind the nurse or her husband as translators, but *"I don't want my son to translate. Not because I am ashamed that he would know of my medical problems, because we have a very close relationship. I don't want to burden the child, because things are already difficult enough, and he is still a child"*. The other patient said: *"It is not pleasant for my son to translate intimate matters. It is better if someone from the* medical *staff, or a grown up relative, or a friend translates"*.

1.4.4 Physicians' use of medical terminology

Twenty-one of the thirty patients reported that their physicians used medical terminology which they failed to understand. The other seven patients did not have this experience.

Jewish-Israeli patients: Two JI patients, male and female, did not meet with physicians who used incomprehensible medical terminology. Five male and three female patients, however, sometimes had this experience. Three males and two females restrained themselves from asking

for clarifications. A male patient said: *"Some physicians let Latin medical terms slip into the conversation, which I don't understand. Sometimes I catch a word and ask, but mostly I am embarrassed, and I also feel there is not enough time for the physician to explain every word"*. Another male patient reported that he sometimes asks for clarification, *"but mostly I don't, because it is not so important. What is important is that the physician knows exactly what should be done"*. A male patient thought that physicians have their own language and terminology, which serves their medical purposes. *"The medical language is part of the physician's profession, and it is not the patient's business. How will they explain medical terms to me, which I know nothing about?"*

A female patient said that the use of medical terminology annoyed her. *"I don't mind them speaking like this, but let them explain, because it is me they are talking about"*. She did not feel free to ask, because *"they don't treat me nicely when they answer"*. Two male patients reported that they rarely came across physicians who used obscure medical terminology. When they did, the physicians willingly explained the meaning and were patient and friendly.

Arab-Israeli patients: Two AI patients, male and female, did not see physicians who used medical terminology. Five males and three females had encounters with physicians who used medical terminology that they failed to comprehend. Two patients were dissatisfied with physicians' use of medical terminology. A female patient reported: *"I have to ask a lot of questions because he uses Latin words, and I really understand my medical problem. When more than one physician is present, they use a lot of Latin words and unclear terms, and it seems like a certain haughtiness on their part"*. A male patient said: *"Physicians who use medical terminology are a problem. It aggravates and annoys me. They speak among themselves in unclear terms in my presence, and mostly they are reluctant to answer when I ask. I think it is my right to know everything about my problem, and it is their obligation to clarify unclear terminology"*. A male patient thought that physicians regularly use unclear medical terminology, and reported that he asks for and receives explanations for every one of these words. *"I must get an exact explanation for every word, otherwise I cannot create a common language with my physician"*.

Two male patients did not mind their physicians' use of medical terminology. They thought that understanding the conversation in general was important, and asking about a word or two would interrupt the flow of conversation. One patient said: *"I don't ask all the time, only if it is very important, because not every word counts. It is important to understand what it is all about, and physicians are too busy to answer on every word"*.

Immigrant patients from the FSU: One male and two female FSU immigrants reported that their physicians did not use medical expressions they did not understand. Four patients met with physicians who used incomprehensible medical terms. Two male and two female patients did not feel comfortable asking the meaning of medical terminology. A female patient said that her physician sometimes uses words she does not understand, and she feels uncomfortable asking. *"I am embarrassed that the physician will know I don't understand what he says"*. A male patient said: *"Sometimes the physician uses Latin terms, and usually I don't ask what it means. I am a little shy, and I don't want to bother and ask too much, I just ask what seems really important"*. A male patient noticed that physicians sometimes use Latin words which he failed to understand and he then asks for further explanations. A female patient reported: *"I hardly ever felt the words were unclear, and I don't mind asking for clarifications"*.

1.5 Time as a factor in the medical encounter

Fifteen of the thirty patients felt the time spent with their physicians was adequate, while fifteen felt the time was inadequate. Lack of time was reported to have a negative effect on the visit's atmosphere, and on the amount of information received and questions asked by the patients.

Jewish-Israeli patients: Three male and two female JI patients felt that the encounter's duration was suitable for their needs and that they did need more time. On the other hand, three males and two females reported feeling the physicians had not spent enough time with them. The patients who felt that the encounters were too short reported this lack of time influenced information-seeking and giving as well as their feelings concerning the visit.

Information-seeking and giving: All the JI patients who complained about lack of time thought they did not receive all the information they wanted. One expression was: *"If there had been more time, I would have asked for more information from the physician, because I feel I need more information"*. Another patient said: *"If we had had more time, the physician would have explained the problem in more detail way, and what it means from my point of view. This could have eased my feelings of uncertainty"*. Another patient said: *"I do understand that physicians suffer from shortage of time, and that patients must settle for practical answers, but I feel I needed more time to receive more information"*. Information-seeking by patients was strongly correlated with question-asking. Three males and one female thought that limited time prevented them from asking all the questions they had in mind. One patient said: *"More time and a slower pace of the visit would have enabled me to ask all my questions and to get more detailed information"*.

Patients' feelings: All the JI patients reported that shortage of time had a negative effect on their perception of the encounters. More time would have contributed to an improved

atmosphere, a more calm and pleasant feeling, and enhanced personal relations between patient and physician. One patient said: *"I want to become friendly with my physician and to establish more personal contact with him. I want him to learn to know me as a person, but the shortage of time makes this impossible"*. Other patients claimed: *"With more time physicians could show patients they really care about them, which is essential for me as a patient"*, and *"when I visit a physician who has no time for me, I am sorry I even came to see him"*. Two patients felt that more time could have been used to discuss personal problems and on other issues, but never had a chance to do so. *"I wanted to discuss my problems and consult the physician, but I was afraid to become a burden on my physician or to feel that I am nagging him"*.

Among JI patients, one male and one female compared the encounters with the treating physician to visits with their family physicians, who devoted much more time to the visit. They said: *"With my family physician I have time to talk about my personal issues"*, and *"with him I can create a personal contact and I can spend more time"*. One patient compared *"young and modern"* physicians to the physicians of the *"old school"*. She said: *"The senior physicians do not let their patients share their knowledge and do not spend a lot of time with them, while the young generation of doctors tend to devote much more time to their patients and establish closer relations with them"*.

Arab-Israeli patients: Four male and two female Arab-Israeli patients reported spending an adequate amount of time with their physicians and did not feel a desire for more time. Two male and two female patients thought the time spent with their physicians was too short. Similar to the JI patients, the AI patients who felt the encounters were too short reported that this influenced two aspects of the encounter: information-seeking and giving and their feelings concerning the visit.

Information-seeking and giving: All four Arab-Israeli patients complained about lack of time. They said this prevented them from fully understanding their medical problems and treatment, and from asking all the questions they wanted to ask. They expressed these feelings in various ways: *"I only ask what I think is urgent, and since I feel the physician is under pressure of time, I mostly don't ask anything at all"*; *"I feel that I do not get enough information because there is no time, and I feel that the doctor does not want to answer"*, and *"I know that physicians are always pressed for time, so I speak concisely, and I don't like to intrude and to ask too many questions, but I don't get the information I want"*.

Patient feelings: All four AI patients felt that lack of time influenced the atmosphere of the encounter, and that more time would have improved relations with the physicians. One patient wanted *"to become friendlier with the doctor in order to be able to tell him more about my*

problems". He wanted to speak about his private life, his family, his job, and to become better acquainted with his physician, and he regretted the fact that it was impossible to establish such a relationship. He said this could have created a more open and pleasant atmosphere, and otherwise he felt stressed. Another patient wanted more time to establish *"a common language"* with his physician, *"to address him like a friend or a family member, in order to establish my faith in this doctor and in what he recommends"*.

Three males and one female compared the visits with their treating physicians to other physicians with whom they consulted. Two patients regularly consulted with their Arabic-speaking family physicians, and felt *"that with him I can speak longer, and discuss personal things before we get into the medical detail, which serve as an introduction to the visit and has a calming effect"*. One patient consulted mainly with physicians *"that I know from my social life, and when I visit them as a patient, they take more time to spend with me, and they are friendly and patient"*. He thought *"it is important to become friends with your doctor, and once he is your friend, he will treat you as a person, as a friend, and then you can get into the medical details"*.

Immigrant patients from the FSU: One female and three male FSU immigrant patients reported spending enough time with their physicians. They said: *"We talked about all that is necessary"* or *"I talk as much as I need to know"*. One male and five females felt that the time given by the physician was insufficient and that it negatively affected their understanding of the information as well as the visit's atmosphere.

Information-seeking and giving: One female FSU immigrant patient said: *"I very much want to visit a physician who takes the time to hear more about issues that worry me, both medical and personal issues, but this has never happened to me yet"*. Another patient felt that *"physicians never have enough time. They are trying, but they are so busy, and I need more time to better understand the medical details, and I also want to discuss personal problems"*. One patient stated: *"I need more time to formulate my questions in Hebrew, and because there is never enough time, I am too embarrassed to ask my questions"*. All these patients felt they could not ask all their questions, thus preventing them from better understanding their medical problems and treatment. One patient described the relations when there is not enough time: *"When I feel the doctor is pressed for time, I get nervous and tense. I cannot ask what I want, and I forget what I wanted to know, and I hurry out. Only outside of the room I recall what it was that I wanted to know, and then it is too late"*.

Patients' feelings: The FSU immigrant patients who reported a lack of time were united in feeling that their physicians did not view them with warmth and did not really care for them as

"human beings". One female patient said: *"I want a kind and amicable physician; I want to feel he cares about me"*. Other patients felt stressed with the short encounters, and were hoping to find *"a friendly and caring physician"*. One patient said that lack of time made him nervous and upset, and that it has a negative effect on the atmosphere, especially for older patients like his parents. He thought that older people need more time to explain themselves, and they also need more explanations and more empathy from physicians. Another patient remarked on the long waiting time outside the physician's room. He explained that *"once I entered the room, I myself shortened my stay, and did not feel free to ask a lot of questions, because I knew so many other patients were waiting outside, and this created pressure on my visit"*.

One male and five female FSU immigrant patients reported regularly consulting their Russian-speaking family physicians. They all felt their family physicians spend more time with them and that due to language concordance they communicate better and get more information. The additional time also enables them to learn to know each other, and the physicians take more interest in their private lives and problems. The treating physicians of two patients were Russian-Israeli. These patients felt they spent adequate time with them, and that the language-concordance added to the positive atmosphere of the encounters.

1.6 Physician's communication style

1.6.1 Desire to discuss personal issues

Twenty-one patients wanted to have personal discussions with the physicians, while nine did not express a desire for such discussions.

Jewish-Israeli patients: Three male and one female JI patients did not have the desire to speak about personal matters with their treating physicians. One male patient thought: *"There is no need to tell the physician about personal or emotional things, because the physician is not my friend, and I don't wand to nag. Physicians are busy, and are doing their job, and one should only talk to them about medical problems"*. Another male patient said: *"I want the physician to be medically professional and not to be my psychologist. Personal things are not his business"*. The female patient said: *"I would not initiate a conversation on personal or emotional subjects, but if a physician would ask me, I would freely talk about it"*.

Three male and three female JI patients expressed a desire to tell their physicians about personal matters. One male patient said: *"I would like to become friends with my physician, and to be able to tell him more about myself, but there is never enough time"*. Another male patient thought: *"I want to speak about my private life, because I want the physician to learn to know me, and then she will better understand my medical problems and how they affect my life"*. A

female patient said: *"It is not a must, but I think a physician should want to learn to know his patient in a way that will contribute to his understanding of the person behind the disease"*.

Arab-Israeli patients: Two AI male patients did not think they should initiate a conversation about personal matters. *"I speak about the medical reasons for my visit, and do not feel the urge to talk about personal issues"*. Another expression was: *"It is not the physician's duty to speak about my personal issues, and he should mainly stick to the medical part and do it well. I think physicians are too busy for this"*. One male patient did not want to talk about personal matters at all, *"I don't think the physician should be my friend, and we don't need to discuss things other than medical issues. The physician is a medical authority and that is how I want it to be"*.

Four male and four female AI patients wanted to speak about personal issues during the medical encounter. They identified several conditions for such a conversation to take place. Two male and three female patients wanted the physician to initiate such a conversation, *"because physicians are very busy, and one should not disturb them too much with what is not related to the medical problem. So I only talk about it if the physician starts the subject"*. Two female patients felt they could only disclose personal matters to their Arabic-speaking family physicians. *"With him I can talk about private things and about things that happen at home. He knows me well, and he is like a friend, a brother, and I can tell him a lot, which is good for me"*. A male patient also spoke of the physician as a friend. *"It is important to become friends with the physician, and when you are friends, you can talk about everything, and it is easier to tell him about problems"*. One male and one female thought it was the physician's obligation to take an interest in personal issues, because they influence the patient's medical condition and needs during the medical encounter.

Immigrant patients from the FSU: Two male and one female FSU immigrant patients did not want to speak about matters other than their medical problems. The male patients said: *"The physician is not my friend, and it is not of interest to him"*, and *"I have no need to speak to a person whom I don't know well about my private life"*. The female patient said: *"I have my family for that, I don't need to disturb the doctor"*. However, two male and six female FSU immigrant patients expressed the wish to have personal discussions with the physicians. They mentioned the conditions on which such discussions depend. Four female patients thought it was possible *"only when the physician has enough time"*, and another female patient wanted the physician to initiate the conversation. Otherwise she would not dare take more of his time unless he volunteered. A male patient thought the physician should be like a psychologist, and that the physician and patient should learn to know each other. After they do, it is easier to talk about any subject. Two females and one male found they could only speak about personal matters with their Russian-speaking family physicians. They found these physicians more

understanding and interested in their problems and felt they could make themselves more easily understood.

1.6.2 Raising personal issues during the encounter, and the physician's response

Twelve patients wanted to tell physicians about personal matters, while eighteen patients did not.

Jewish-Israeli patients: Five male and three female JI patients did not speak about personal matters during their medical encounters. Three males and two females reported that the physician did not initiate such a conversation. These patients did not feel comfortable starting a personal discussion since they thought the physicians did not want to hear about their private matters. A male patient said: *"I never initiate such a conversation, and the physician does not either, but I would have liked it to happen, it would have improved to the atmosphere"*. A female patient felt that *"physicians don't have enough time, and therefore I do not have the opportunity to speak about private things. If it were possible, I would have wanted to tell my physician. It would have added to the atmosphere, and minimized uncertainties"*. Another female patient said: *"The physician was patient and friendly, but did not initiate a personal conversation, so I did not feel I could motivate such a conversation"*.

Two males and one female did not think there is any need to involve a treating physician in their personal matters. A male patient said: *"It is not his business, I did not come here to tell the physician stories. What is important is that he should be knowledgeable about the treatment, I need"*. The female patient felt: *"One should not burden the physician with other issues because he is far too busy. This is a conversation for the family physician"*.

One male and one female spoke with their physicians about personal matters, and their physicians joined the conversation willingly. The male patient said that in most of his encounters with his physician, they speak about his private life. *"She asks about things that are connected with medical details, about my interests, my work and about what happens in my life. This makes me feel free with her. I know she cares and that I have an open door with her. It builds up a good relationship, and creates a good atmosphere and mutuality in decisions about my care"*. The female patient said she always speaks to her physicians about personal and emotional matters. She tells them about her family, her children and grandchildren, and feels it creates a good atmosphere. These conversations are initiated by her and by the physicians, *"and I feel like his mother, because he is as old as my son, and I love him like my son. I also tell him that"*.

Arab-Israeli patients: Three male and one female AI patients did not have personal conversations with the physician. The female patient said: *"The physician was impatient and showed no interest in me as a person. I wanted to tell him about my private problems, but he cut me short, was disinterested, and the atmosphere was tense"*. Two male patients reported that physicians did not initiate such discussions, and they did not think that it was right for them to take the initiative. They both agreed they would have responded to such initiative if made by the physician, and that it could have added to a more pleasant atmosphere. The third male patient did not want to speak about personal matters and his physician did not initiate such topics. *"I don't think the physician is my friend, I want the atmosphere to be pleasant, but I have my friends for personal relations"*.

Four male and two female patients spoke about personal issues with their physician. A male patient said: *"It made me feel the physician knows he is a person like me, that he cares about me as a person, and I felt more comfortable telling him about my problems"*. The female patients and a male patient said that the physicians initiated the conversation and were willing to listen. They were very pleasant and encouraging, which created a very good atmosphere. A male patient described the encounter: *"The physician started with a general discussion and we spoke of several things. This created a comfortable atmosphere, and I felt that the physician is first of all a person like me. We were like two equal people, and not like I am the doctor and you are the patient. This gave me a good feeling and I was confident that he could help me"*.

Immigrant patients from the FSU: Three male and three female FSU immigrant patients did not have private conversations with the physicians. A female patient said: *"The physician did not give me the feeling he had the heart to hear about my personal problems and worries, and although I very much wanted to talk to him, it did not seem possible to do it"*. Another female patient reported that she usually does not like to tell too much about herself. She said: *"I told him what is needed and that is all. The physician did not have a lot of time, and I did not want to take away his time on issues not related to my medical problem. I know my limits"*. A male patient said: *"The physician did not ask, and I did not feel it was of interest to him. He is not my friend, and he was busy"*. Another male patient felt: *"He is a specialist and not a family physician, and I did not think it was important to tell about personal things I tell my family physician. He is a stranger to me and I did not feel comfortable talking about such problems"*.

One male and three female FSU immigrant patients had personal conversations with the physician. One male and one female patient reported that the physicians initiated the subject, and they felt comfortable participating in the conversation. They said: *"I knew he was busy, but I was glad he asked, and I felt good telling him about my worries and thoughts"*, and, *"my physician was so friendly. He wanted to know about my family, about problems I have at work,*

and it encouraged me to tell him more about it and made me feel good". A female patient thought that speaking about personal problems was not the main reason for the visit. However, since the physician was friendly and caring, she told about her personal problems in order to let him better understand how she felt and how it affected her condition.

1.6.3 Physician friendliness and humour, and its impact

Twenty-five patients reported that their physicians were friendly, while five did not agree.

Jewish-Israeli patients: Only one female JI patient felt that her physician was unfriendly, and she thought the reason was lack of time. *"I wanted him to be friendly, to ask how I feel and to really care about my answer, but he was short, almost harsh, which made me feel insecure and tense"*. Six male and three female patients reported that their physicians were friendly. A female patient said: *"My physician is very friendly, he smiles a lot, and jokes with me, and I really like it. It is not enough for a physician to have knowledge. Human relations are worth millions. A courteous physician brings happiness to his patient's heart"*. A male patient said: *"I prefer friendly physicians. Some physicians are dry and introverts and I can't warm up to them. I can only ask my questions with a friendly physician, and then I am pleased with the encounter"*. Another female patient felt her physician was friendly and had a sense of humour. This created a pleasant atmosphere and calmed her worries. A male patient thought that laughter and humour relax patients, and they feel less worried. He said: *"A smile always adds to a good feeling"*, and he was satisfied that his physician was friendly and kind.

Arab-Israeli patients: Only one female AI patient complained that her physician was unfriendly. *"He was uninterested in me as a person, and I was stressed. He did not say anything friendly or nice and I longed so much to tell him about my problems, but I could not"*. Six male and three female patients reported that the physicians were friendly. A male patient said: *"My physician started the visit with a joke, which eased the atmosphere and my concerns right from the start. The conversation that followed was good, and I think it enabled me to speak more freely about my medical problems"*. A male patient said that the friendly physician helped open him up and he communicated better with this physician than with others who were not as pleasant. Another male patient said: *"I like it when the physician is friendly, he made some jokes, and I felt relieved, and wanted this doctor to treat me"*.

Immigrant patients from the FSU: One male and two female FSU immigrant patients felt the physicians were unfriendly. The male patient said: *"The physician was strict, like most physicians here, and I was unhappy about it, because in Russia they were friendly, and that calmed me"*. Three male and four female patients reported that the physicians were friendly and

pleasant. They all agreed it made the atmosphere pleasant, and felt the physicians really cared about them. A female patient said: *"He smiled when I spoke, and it was the best medicine he could offer"*. Another female patient reported: *"I was anxious and spoke nervously, and he calmed me down, and was so considerate, that I started telling him about my worries"*. Only two patients, one male and one female, mentioned that the physician told them jokes. They said: *"Laughter helps cure, and I liked his attitude"* and, *"his humour together with his smile are the best medicine"*.

1.7 Gender

1.7.1 Differences between male and female physicians, and patient preference

Thirteen patients described differences between male and female physicians, while seventeen patients found no differences. Three patients preferred male physicians. Three female patients wished to be seen by female physicians, and twenty-four patients expressed no preferences regarding their physicians' gender.

Jewish-Israeli patients: Three male JI patients thought there were differences between encounters with male and female physicians. One patient said: *"I don't think there is a difference in their knowledge, and I don't mind being examined by a female physician, but I think that female physicians have more patience, and they are more pleasant to speak with than male physicians"*. Another patient found that *"female physicians, in my experience, are more sensitive than male physicians. I met with a female physician who was gentle and considerate. She was patient and explained everything I wanted to know step by step, so that I could follow her thoughts. The visit was very pleasant"*. The third patient reported that *"in intimate body examinations performed by a female physician, I tend to be embarrassed, and I feel more at ease with a male physician. When I was younger, I used to blush when she examined me, but now I got used to her, and I feel better about it"*.

Three male and four female patients found no differences between male and female physicians. A female patient said: *"I don't find a difference, and I don't mind being examined by a male physician. I am not shy. What is important is to have a professional and skilled physician"*. Another female patient thought that *"the differences lie in the character and not in the gender"*. A male patient felt that *"I had good and bad experiences with physicians of both kinds, and the truth is that it all depends on the person's character"*. All ten JI patients stated no preference, and did not care if their physician is a male or a female, as long as they are good and professional.

Arab-Israeli patients: Three male and three female AI patients thought there are differences between male and female physicians. Two female patients felt that *"with a female physician I am less shy and embarrassed"*, and *"I feel more comfortable talking to her, because female physicians listen more patiently to my questions, and give more answers and more information"*. Two male patients found that *"a woman is mostly gentle and pleasant, and female physicians treat you kindly, which makes the encounter more pleasing"*. However, three male patients did not want to be examined by a female physician. They said: *"I am religious, and I prefer to be examined by a man"*, and *"I don't mind speaking to a female physician, but I prefer to be examined by a male physician"*. A third male patient said: *"I shall not let a woman examine me, this is not logical"*. One of them also felt *"more at ease and able to speak freely to a male physician"*.

Three males and one female thought there is no gender difference, and did not mind seeing a physician of the opposite gender. They all agreed that *"a physician is a physician, the main point is that they should be good professionally, and kind"*. Another expression was: *"They are all human beings, and have to do their job well"*. Two female patients preferred to be seen and examined by female physicians, and the other eight AI patients did not express any preference, as long as the physicians are *"kind and professional"*.

Immigrant patients from the FSU: Two female and two male patients found differences between male and female physicians. A female patient said: *"I feel more comfortable with a woman, because I am shy, and when a male physician examines me, his hands are different, I can feel that it is a man"*. The other female patient preferred to have a male physician. She said: *"A male physician is more professional, he only thinks about his work. A female physician has all kinds of things to think about, like any other woman, who takes care of the house and the children. It occupies her at work too, and she is less immersed in her work"*. One male patient felt that *"a man needs a male physician"* and the other male patient said: *"Professionally, I don't think there is a difference, but in intimate examinations it is more comfortable when a man examines you. Concerning the human relations of the physicians, this depends on the personality and not on the physician's gender"*.

Two male and four female FSU immigrant patients did not find differences between male and female physicians. They identified the qualities important in a physician, regardless of gender. *"It is important for the physician to have a good, warm heart, and to be humane"*, and *"what is important is medical knowledge, a humane attitude, a smile and reassurance, and to have more time with the patients"*. Another patient said: *"Their knowledge counts, and their human relations. It is important that the physician pay attention to the patient"*. One female patient

preferred to be seen by a female physician. Two males and one female preferred to be treated by male physicians. Two males and four females did not express any preferences.

1.7.2 Gender preference in discussing personal issues

Seventeen patients were able to speak with both male and female physicians about personal matters. Two patients preferred to talk to male physicians, and seven patients preferred female physicians. Three patients did not want to initiate personal conversations, and four patients did not want to speak about personal matters with their physicians at all.

Jewish-Israeli patients: When speaking of personal issues, eight JI patients did not find a difference between male and female physicians. One female patient said: *"I don't think a female physician is more open or friendly than a male. My physician is a male, he is friendly and kind, and I can tell him everything"*. A male patient said: *"I speak to a male or female physician about the same things, even emotional subjects, without any problem or shame"*. Two male patients found they could speak more freely to female physicians about personal issues. *"Maybe because women are more sensitive, and it's easier and more pleasant to get into personal conversations with them"*. One male and two female patients did not want to initiate conversations about personal issues with their physicians.

Arab-Israeli patients: Two male AI patients did not mind telling either a male or female physician about their personal issues. *"I don't see a difference between telling a male or female physician about my personal problems, as long as they are open and friendly"*. One male and three female patients preferred speaking to female physicians about personal matters. The male patient found female physicians more kind and friendly, and claimed it was easier and more comfortable speaking with female physicians about personal issues. A female patient said: *"I think a female physician will identify more with me as a patient. I can tell her more, because she is a woman like me, and women better understand each other"*. Another female patient expressed a warm desire to speak to a female physician, *"I wish I had a female physician. I very much want to talk about personal and emotional matters, and I am embarrassed to tell my male physician. A woman would be more understanding and humane"*.

One female AI patient who was examined by an AI physician felt comfortable telling him about her personal issues, *"because he initiated the conversation, and he was so friendly, and I could speak to him in Arabic, and open my heart. It was pleasant to find a physician who also takes interest in other things"*. Three male patients did not feel the need to speak to their physicians about personal matters.

Immigrant patients from the FSU: Two male and five female patients thought they could speak to both male and female physicians about personal issues, *"as long as the physician is courteous"*. A female patient said: *"It depends on the physician's personality. With a friendly and pleasant male physician I can talk about personal problems freely"*. One female patient felt *"it is easier to tell a woman about personal issues, and I am shy of male physicians"*. One male patient reported: *"I hardly talk about more personal matters, because I don't like to speak about them at all, but if I would want to, I can't see myself talking about it to a female physician"*. One male patient did not wish to speak to a physician about personal issues at all.

1.8 Choosing what is most important in relations with the physician

During the final portion of the interview, patients identified six aspects of the medical encounter that they valued as important and desirable.

1.8.1 Information disclosure and question-answering

Jewish-Israeli patients: Four male and three female JI patients addressed information disclosure and question-answering as an important aspect of their relationship with their physicians. They all agreed that *"it is important that physicians provide information, explain and tell patients what they want to know"*. A female patient said: *"The ideal physician should volunteer the information, initiate these explanations for the patients, and patients should be able to ask all their questions. Physicians should be open and tolerant of the patient's need for information"*. A male patient expressed the desire *"to learn more from physicians about improvements and innovations in medicine, to feel that physicians share their knowledge with the patients"*. Three patients made a correlation between lack of sufficient information and physicians' shortage of time. These factors prevented them from asking more questions.

Arab-Israeli patients: Three male and one female AI patients wished to receive more information from physicians. A male patient said: *"I don't want to receive superficial explanations, I want the physician to involve me in a detailed conversation, which deals with all that I want to know"*. Another male patient said: *"Asking questions and finding out things prior to an important step is the patient's right"*. They claimed that sufficient information provided by the physician enables patients to better understand their medical problems and to make the right decisions about their care. It also increases patients' trust in the physicians.

Immigrant patients from the FSU: One male and three female FSU immigrant patients wanted to meet with physicians who provide more information than they usually receive. They identified several reasons for seeking additional information. More detailed information calms patients and increases their trust; *"It is appeasing, it alleviates worries about the future, and*

establishes trust in the physician, when you know what the problem is and how to go about solving it". Patients wanted a mutual exchange of information with the physicians: *"It is important for the physician to understand the patient and to listen to him, and he should provide the patient with accurate, logical information, and explain everything to him"*. Patients also wanted physicians to answer more questions: *"I want him to volunteer more information, I want to ask question and thereby better understand my problem and its suggested treatment"*.

1.8.2 Personal and humane attitude

Jewish-Israeli patients: Three male and four female JI patients emphasized that personal relations with the physician were essential. They wanted attention, understanding, friendliness and a humane attitude. These characteristics were believed to create positive relations and improve the atmosphere of the medical encounter. These seven patients were very sensitive to this issue and stressed *"a personal and positive approach makes me feel that the physician cares about me, that I am not just a medical specimen or an observation target"*. A female patient felt: *"It is not enough if he has the knowledge, a pleasant physician brings happiness to the patient's heart"*. A male patient said: *"I want my physician to treat me like a human being, to address my pain and show more concern for me"*. Another female patient found that physicians treat specific medical problems but tend to forget the person behind the disease. Four patients expressed a desire for friendly physicians who create a warm atmosphere that reduces patients' anxiety.

Arab-Israeli patients: Five male and three female AI patients highly valued physicians' personal, humane relations. A female patient said: *"Let him first of all be a human being, feel the patient's pain"*. Another female patient wished *"physicians to be gentle, to speak nicely, to have a good heart. This adds strength to the medication when the physician is nice"*. Four males and one female mentioned friendliness as a desired virtue. *"May he be pleasant and friendly, and not boastful or impatient"*. A male patient said: *"The physician needs to be able to understand his patient and to adjust the treatment to him. He must provide human relations to every patient in the manner that suits this patient"*.

Immigrant patients from the FSU: Nine out of ten FSU immigrant patients began the conversation with physicians' humane and personal relations. Four patients, two male and two female, used the expression *"ben adam"*, namely a humane human being, when describing the desired characteristics of a physician. The patients used emotional statements: *"The most important thing is that the physician should be a ben adam"*, and *"the physician should have more heart for his patient"*. Patients wished to receive comfort and attention: *"He should have a kind attitude, a smile and reassurance for the patient"*, and *"I want him to be pleasant,*

patient and friendly". Two male patients were concerned with the physician treating the body as a whole: *"It is important that the physician listen to the patient, and not just address the specific problem presented now. He should be concerned with the body as a whole, with the human being, and understand that his body is ill and the medical problem concerns his body and his mind"*.

1.8.3 Professional knowledge and humane approach

Jewish-Israeli patients: Four male Jewish-Israeli patients thought the ideal physician combines professional knowledge with humane personal relations. *"The physician's knowledge is important, and so is the communication between him and the patient. The physician should have the information and provide it, he should alleviate patients' fears, and respond to patients"*. Another expression was: *"It is important that the physician be good professionally and in human relations. A smile helps at the right time and so does a professional and serious attitude"*.

Arab-Israeli patients: Three males and one female wanted physicians to combine the two virtues of professional knowledge and humanity. The female patient said: *"The physician needs to be professional, but it is most important for him to be humane. His smile gives power to cope with the disease"*. A male patient wanted the physician *"to be an authoritative and professional personality, and a human being, and to treat his patient as a human being. It is not right when a physician works well, but is not nice"*.

Immigrant patients from the FSU: Three male and three female patients stressed the importance of the combined virtues of humanity and professionalism. A male patient said: *"The physician should be good professionally, but it is also very important that he have a good heart"*. A female patient thought: *"Some physicians are professional, but you feel they treat you like air. They do not pay attention to you, they seem to hear and not hear you, and this is very difficult. A physician should know his profession well, but he must be a ben adam"*. Another explanation was: *"It is important that he have a lot of medical knowledge, but a conversation about personal matters will enable him to understand what the patient is going through, and all it takes is one good word from him to improve the situation"*.

1.8.4 Sufficient time offered by physicians

Jewish-Israeli patients: Shortage of time during the encounters was an important factor for five JI patients. They wanted physicians to volunteer more time for several reasons. Two male and three female patients felt that lack of time causes physicians to give insufficient information, and prevents patients from asking all their questions. *"I would like to have sufficient time to*

receive more information and to feel comfortable asking all my questions". A male patient felt that *"a physician who is pressed for time does not learn to know you well"*. One male and two female patients felt that shortage of time negatively affects the atmosphere. *"Lack of time influences the atmosphere, and creates a feeling of uncertainty"*.

Arab-Israeli patients: Three male and two female AI patients wanted physicians to spend more time with them. They said that lack of time negatively affects the atmosphere, and makes them angry and nervous. *"More time would create a calm atmosphere"*, and *"I need more time to develop an open and friendly conversation"*. All these patients felt that more time would enable them to ask more question and to better understand the physicians. One male patient said that more time also enables physicians to examine patients more thoroughly.

Immigrant patients from the FSU: One male and three female patients were concerned with physicians' shortage of time. They felt that physicians are regularly pressed for time, and wished they could spend more time with the physicians. Additional time would be used to ask more questions, and receive more information, to clarify uncertainties, and to improve the atmosphere. *"When the physician is pressed for time, I get stressed, and forget what I wanted to ask"*. Two female patients felt that lack of time leads to insufficient information, *"which causes uncertainty and stress"*. All three female patients mentioned the encounter's atmosphere:" *It is calming when the physician has more time, and gives more explanations"*, and *"when there is time, we can speak of personal things, and the atmosphere improves and relations become more personal"*.

1.8.5 Overcoming language difficulties

Arab-Israeli patients: One male and three female AI patients felt that language difficulties prevented them from understanding medical information, from asking questions, and from having friendly relations with language non-concordant physicians. They wished to meet with Arabic-speaking physicians with whom they can create friendships and disclose personal matters. A female patient felt: *"I can only speak about my personal problems and about what happens at home with physicians who speak my language, and this way we create a relationship of friends, and the physician becomes like a friend. I can tell him more and it is good for me to speak not only about my medical problems"*.

Immigrant patients from the FSU: Two male and five female FSU immigrant patients spoke of language difficulties and how these affect the encounters. They said the language barrier prevents them from establishing personal relations with physicians, *"I want to speak about personal things, but I can only do so with a Russian speaking physician"*. Language difficulties

cause misunderstandings and lack of information. *"It is difficult to ask questions when you don't speak the language well, to verbalize your thoughts. With a Russian-speaking physician I can speak about details, ask questions, and better understand the issues"*, and *"I don't understand well what the physician says, and he doesn't understand me"*.

1.8.6 Participatory decision-making

Jewish-Israeli patients: Two JI patients, one male and one female, wanted their physicians to explain their treatment options and to share decisions with them. *"I want to feel we are in a mutual consultation and decision-making, and that my choices are right, according to the physician's recommendations"*.

Arab-Israeli patients: Two AI patients, one male and one female, wished to be seen by *physicians "who will be open to accept my opinion and my decisions"*. The male patient wanted *"the physician to take me seriously, to examine me thoroughly so that we can reach a mutual decision based on serious knowledge"*.

Immigrant patients from the FSU: One male patient wanted to be seen by physicians who would let him participate in treatment decisions. He claimed he was never offered to share decision with his physicians and stated that, *"to make the patient a partner in decision-making is ideal, but my physicians always guarded their authority"*.

Appendix C: Questionnaires

Appendix C1: Questionnaires in Hebrew, Arabic, Russian, English - pre-test No. 1

Questionnaire in Hebrew

טופס הסכמה מדעת

אנו עורכים מחקר העוסק בעמדות מטופלים כלפי טיפול רפואי. המחקר הינו אנונימי, אנו מבקשים את שיתוף הפעולה שלך במילוי שאלון קצר שישקף את העמדות שלך. במידה והינך מסכים לקחת חלק במחקר ולהשיב על השאלון, אנא מלא את ספח ההסכמה הרצ"ב.

אני החתום מטה:

שם פרטי ומשפחה:	
מספר תעודת זהות:	

א) מצהיר/ה בזה כי אני מסכים/ה להשתתף במחקר, כמפורט במסמך זה.
ב) מצהיר/ה בזה כי הוסבר לי על ידי

שם המסביר:

1. כי אני חופשי/ה לבחור שלא להשתתף במחקר, וכי אני חופשי/ה להפסיק בכל עת את השתתפותי במחקר.
2. כי מובטח שזהותי האישית תשמר בסודיות על ידי כל העוסקים והמעורבים במחקר ולא תפורסם בכל פרסום כולל בפרסומים מדעיים.

הצהרת החוקר/חוקר משנה/המסביר:

ההסכמה הנ"ל נתקבלה על ידי וזאת לאחר שהסברתי למשתתף/ת במחקר כל האמור לעיל וכן וויידאתי שכל הסברי הובנו על ידו/ידה.

תאריך:	חתימתו:	שם המסביר:

שלום רב,
השאלון שלפניך נערך במסגרת מחקר על עמדות מטופלים כלפי הטיפול הרפואי.
המחקר הינו אנונימי והינך מתבקש לא לציין את שמך או פרטים מזהים אחרים בגוף השאלון.
תשובותיך יהיו חסויות, יישמרו בסודיות מוחלטת אצל עורכי המחקר בלבד וישמשו לצרכים סטטיסטיים בלבד. לבית החולים ולצוות הרפואי לא תהיה אפשרות לדעת אילו תשובות בחר כל מטופל ומטופל.
בשאלון שלפניך אין תשובות נכונות, אנו מעוניינים לקבל את דעתך האישית.
אתה מתבקש להתייחס בתשובותיך לביקור שלך <u>היום</u> אצל הרופא.
מטעמי נוחות, מנוסח השאלון בלשון זכר, איתכן הסליחה.
בשאלון שלפניך מדורגות התשובות על סולם מ- **1** עד **5**, כאשר **1**=כלל לא מסכים,
2=מסכים במידה מועטה, **3**=מסכים במידה בינונית, **4**=מסכים במידה רבה,
5=מסכים במידה רבה מאד, **0**=לא רלוונטי.

אנא סמן ב- **X** את הדרגה המתאימה ביותר לדעתך.

1. שנת לידה: _____

2. שנת עלייה לישראל: _____ 3. ארץ לידה: _____

4. מין: □[1] זכר □[2] נקבה

5. מצב משפחתי: □[1] רווק □[2] נשוי □[3] גרוש
□[4] אלמן □[5] פרוד □[6] אחר

6. דת: □[1] יהודי □[2] מוסלמי □[3] נוצרי □[4] דרוזי □[5] אחר

7. מספר שנות לימוד: _____

8. מידת שליטה בשפה העברית:
□[1] בכלל לא □[2] מועטה □[3] בינונית □[4] טובה □[5] טובה מאד

9. האם הגעת לביקור לבדך? □[1] כן □[2] לא
אם לא, מי התלווה אליך? □[1] אב □[2] אם □[3] אח □[4] אחות
□[5] בעל □[6] אישה □[7] בת □[8] בן
□[9] קרוב משפחה אחר □[10] חבר/ה □[11] אחר

10. השפה בה התנהל הביקור: □[1] עברית □[2] ערבית □[3] רוסית

11. האם מישהו תרגם בזמן הביקור? □[1] כן □[2] לא
אם כן, מי תרגם? □[1] אב □[2] אם □[3] אח □[4] אחות □[5] בעל
□[6] אישה □[7] בת □[8] בן □[9] קרוב משפחה אחר
□[10] חבר/ה □[11] איש צוות רפואי □[12] אחר

12. הביקור נערך אצל: □[1] רופא □[2] רופאה

	באיזו מידה אתה מסכים עם כל אחד מהמשפטים הבאים?	לא רלוונטי	כלל לא	במידה מועטה	במידה בינונית	במידה רבה	במידה רבה מאד
.1	הרופא הסביר לי כל מה שרציתי לדעת על הבעיה הרפואית שלי ועל דרך הטיפול	0	1	2	3	4	5
.2	הרופא הסביר לי על תוכניותיו לגבי הטיפול שלי	0	1	2	3	4	5
.3	הרגשתי שאני יכול לדבר עם הרופא על עניינים אישיים	0	1	2	3	4	5
.4	לא הבנתי את כל מה שהרופא אמר לי, כי הוא לא מדבר את השפה שלי	0	1	2	3	4	5
.5	הרופא רצה לשתף אותי בקבלת ההחלטה על הטיפול שלי	0	1	2	3	4	5
.6	הייתי מעדיף להיבדק ע"י רופאה ולא ע"י רופא	0	1	2	3	4	5
.7	הרופא הפסיק אותי לעתים קרובות בזמן השיחה שלנו	0	1	2	3	4	5
.8	חשוב לי שהרופא יסביר לי הכל על הבעיה הרפואית שלי ועל דרך הטיפול	0	1	2	3	4	5
.9	הייתי מעדיף להיות מטופל ע"י רופא שמדבר את השפה שלי	0	1	2	3	4	5
.10	הרגשתי שהרופא מתעניין בי כבן אדם	0	1	2	3	4	5
.11	אני רוצה שהרופא יחליט בשבילי מה הטיפול הטוב ביותר עבור הבעיה הרפואית שלי	0	1	2	3	4	5
.12	היה לי מספיק זמן כדי לשאול את הרופא את כל מה שרציתי לדעת	0	1	2	3	4	5
.13	הרופא ענה על כל השאלות שלי	0	1	2	3	4	5
.14	הרופא עודד אותי לדבר על הדאגות שלי	0	1	2	3	4	5
.15	הרגשתי שהרופא לא הבין את מה שאמרתי לו, כי הוא לא מדבר את השפה שלי	0	1	2	3	4	5
.16	יש מספר דברים שיכלו להיות טובים יותר בביקור שלי אצל הרופא	0	1	2	3	4	5
.17	אני רוצה לקבל מידע נוסף על הבעיה הרפואית שלי מקרובי משפחה	0	1	2	3	4	5
.18	אני רוצה שהרופא ישתף אותי בהחלטה על הטיפול בבעיה הרפואית שלי	0	1	2	3	4	5
.19	הרופא דבר בצורה ברורה והבנתי את מה שהוא אמר לי	0	1	2	3	4	5
.20	הרגשתי שהרופא ממהר	0	1	2	3	4	5
.21	הרופא עודד אותי לשאול שאלות	0	1	2	3	4	5
.22	אני רוצה להתייעץ עם המשפחה שלי בקשר לטיפול בבעיה הרפואית שלי	0	1	2	3	4	5
.23	הרופא נתן לי הסברים במילים שלא הבנתי	0	1	2	3	4	5
.24	הייתי רוצה שהרופא יקדיש לי יותר זמן	0	1	2	3	4	5
.25	הרופא היה זה שדבר ברוב זמן הביקור	0	1	2	3	4	5
.26	הייתי רוצה להיות מעורב בהחלטה על הטיפול שלי יותר מכפי שהרופא אפשר לי	0	1	2	3	4	5
.27	לעתים הרופא התנשא מעלי	0	1	2	3	4	5
.28	אני מרגיש נוח יותר לדבר על בעיות רגשיות עם רופאה	0	1	2	3	4	5
.29	הרופא אפשר לי להגיד כל מה שרציתי	0	1	2	3	4	5
.30	הייתי מעדיף להיבדק ע"י רופא ולא ע"י רופאה	0	1	2	3	4	5
.31	הרופא ואני צחקנו והתבדחנו בזמן הביקור	0	1	2	3	4	5
.32	הרופא הסביר לי בברור את הבעיה הרפואית שלי	0	1	2	3	4	5
.33	אני רוצה להתייעץ עם הרב / השייך / הכומר בקשר לטיפול בבעיה הרפואית שלי	0	1	2	3	4	5
.34	אני שבע רצון מהטיפול הרפואי שקבלתי אצל הרופא	0	1	2	3	4	5
.35	הזמן שניתן לי אצל הרופא היה קצר מדי	0	1	2	3	4	5
.36	הרופא הסביר לי את האפשרויות השונות לטיפול בבעיה הרפואית שלי	0	1	2	3	4	5
.37	אני רוצה לקבל מידע נוסף על הבעיה הרפואית שלי על ידי חיפוש באינטרנט	0	1	2	3	4	5
.38	הרגשתי שאני זקוק למישהו שיתרגם בזמן הביקור	0	1	2	3	4	5
.39	הרופא התייחס אלי בהערכה ובכבוד	0	1	2	3	4	5

	באיזו מידה אתה מסכים עם כל אחד מהמשפטים הבאים?	לא רלוונטי	כלל לא	במידה מועטה	במידה בינונית	במידה רבה	במידה רבה מאד
.40	הרופא הקשיב לכל מה שאמרתי	0	1	2	3	4	5
.41	הרגשתי שהרופא באמת מבין אותי	0	1	2	3	4	5
.42	אני רוצה להתייעץ עם חברים בקשר לטיפול בבעיה הרפואית שלי	0	1	2	3	4	5
.43	אני צריך יותר זמן כדי להכיר את הרופא, לפני שאני יכול לספר לו על הבעיה הרפואית שלי	0	1	2	3	4	5
.44	בעקבות השיחה עם הרופא אני מבין הכל על הבעיה הרפואית שלי	0	1	2	3	4	5
.45	הייתי מעדיף שמישהו אחר, ולא בן משפחה שלי, יתרגם בזמן הביקור	0	1	2	3	4	5
.46	הרופא התעניין במשפחה שלי ובחיי הפרטיים	0	1	2	3	4	5
.47	אני מרגיש נוח יותר לדבר על הבעיות הרפואיות שלי עם רופא ולא עם רופאה	0	1	2	3	4	5
.48	אני שבע רצון מהביקור שלי אצל הרופא	0	1	2	3	4	5

Questionnaire in Arabic

إستمارة موافقة مثبت

نجري بحثاً يُعنى بمواقف المعالجين تجاه العلاج الطبي، دون ذكر أسماء المرضى المعالجين. نرجو منك تعبئة إستمارة قصيرة التي تعكس مواقفك. في حالة موافقتك على الإشترك بالبحث وتعبئة الإستمارة, ترجى تعبئة ملحق الموافقة المرفق بهذا.

أنا الموقع أدناه:

الإسم الشخصي وإسم العائلة:	
رقم بطاقة الهوية:	

أ) أصرح بهذا بأني موافق/ة على اشتراك في هذا البحث, كما هو مفصل في هذه الإستمارة.
ب) أصرح بهذا أنه وُضّح لي من قِبل:

إسم الشخص الذي قام بالتوضيح:

1) أنني حر/حرة في عدم الإشتراك في البحث, وأني أستطيع أن ألغي إشتراكي في أي لحظة.
2) وُعدت بأن رقم بطاقة هويتي سيحفظ بسرية، على يد كل العاملين والمشتركين في هذا البحث، ولن تنشر في أي إصدار بما في ذلك إصدارات علمية.

تصريح الباحث/الباحث الثانوي/الموَضّح:

الموافقة أعلاه أخذت على يدي وذلك بعد أن شرحت للمشترك/ة في البحث كل ما ذكر أعلاه وتأكدت أن جميع شروحي قد فُهمت من قبله/ها.

التاريخ:	توقيعه	إسم الموضح

مرحباً،
الإستمارة التي أمامك صممت في نطاق بحث عن مواقف المعالجين من العلاج الطبي. البحث هو سري ويطلب منك أن لا تذكر إسمك أو أي تفاصيل شخصية في الإستمارة.
أجوبتك ستكون سرية، تحفظ سراً عند القائمين على البحث وتستعمل الإجابات لأهداف إحصائية فقط. لن يكون لدى المستشفى والطاقم الطبي أي إمكانية لمعرفة أجوبة المعالجين.
بالإستمارة التي أمامك لا توجد أجوبة صحيحة، نحن معنيون بالحصول على رأيك فقط.
يطلب منك أن تتعرّض في إجاباتك للزيارة التي قمت بها اليوم لدى الطبيب.
لقد تمت صياغة الأسئلة بصيغة المذكر للتسهيل فقط، فمنكن المعذرة.
بالإستمارة التي أمامك تم تدريج الأجوبة في سلم من 1 حتى 5، حيث أن 1=لا أوافق أبداً، 2= أوافق بدرجة قليلة، 3=أوافق بدرجة متوسطة، 4=أوافق بدجة كبيرة، 5=أوافق بدرجة كبيرة جداً، 0=لا علاقة بالموضوع.
رجاء الإشارة بـ x للدرجة الأكثر ملاءمة حسب رأيك.

1. سنة الولادة: _____
2. سنة الهجرة إلى إسرائيل: _____ 3. دولة الولادة: _____

4. الجنس: □[1] ذكر □[2] أنثى

5. الوضع العائلي: □[1] أعزب □[2] متزوج □[3] مطلق □[4] أرمل □[5] منفصل □[6] آخر

6. الديانة: □[1] يهودي □[2] مسلم □[3] مسيحي □[4] آخر

7. عدد سنوات التعليم: _____

8. مدى السيطرة على اللغة العبرية:
□[1] لا أجيدها □[2] قليلة □[3] متوسطة □[4] جيدة □[5] جيدة جداً

9. هل وصلت الزيارة لوحدك؟ □[1] نعم □[2] لا
إذا كانت إجابتك لا، من رافقك؟ □[1] الأب □[2] الأم □[3] الأخ □[4] الأخت □[5] الزوج □[6] الزوجة □[7] الإبنة □[8] الإبن □[9] قريب آخر □[10] صديق/ة □[11] شخص آخر

10. اللغة التي دارت بها الزيارة: □[1] العبرية □[2] العربية □[3] الروسية

11. هل ترجم أحد خلال الزيارة؟ □[1] نعم □[2] لا
إذا كانت الإجابة نعم، فمن؟ □[1] الأب □[2] الأم □[3] الأخ □[4] الأخت □[5] الزوج □[6] الزوجة □[7] الإبنة □[8] الإبن □[9] قريب آخر □[10] صديق/ة □[11] شخص من الطاقم الطبي □[12] شخص آخر

12. كانت الزيارة لدى: □[1] طبيب □[2] طبيبة

بأي مدى توافق مع كل واحدة من الجمل التالية؟		لا علاقة بالموضوع	لا أوافق أبداً	أوافق بدرجة قليلة	أوافق بدرجة متوسطة	أوافق بدرجة كبيرة	أوافق بدرجة كبيرة جداً
1	لقد شرح لي الطبيب جميع ما أردت أن أعرفه عن مشكلتي الطبية وطريقة علاجها	0	1	2	3	4	5
2	شرح لي الطبيب مخططاته المتعلقة بعلاجي	0	1	2	3	4	5
3	شعرت أني أستطيع الحديث مع الطبيب حول مواضيع شخصية	0	1	2	3	4	5
4	لم أفهم جميع ما قاله الطبيب، لأنه لم يتحدث لغتي	0	1	2	3	4	5
5	أراد الطبيب إشراكي في إتخاذ القرار حول طريقة علاجي	0	1	2	3	4	5
6	كنت أفضل لو فحصتني طبيبة	0	1	2	3	4	5
7	قام الطبيب بإيقافي عن الحديث عدة مرات خلال المحادثة	0	1	2	3	4	5
8	من المهم بالنسبة لي أن يشرح لي الطبيب كل شيء بخصوص مشكلتي الطبية وطريقة علاجها	0	1	2	3	4	5
9	كنت أفضل أن يفحصني طبيب يتحدث لغتي	0	1	2	3	4	5
10	شعرت أن الطبيب مهتم بي كإنسان	0	1	2	3	4	5
11	أريد أن يقرر الطبيب من أجلي أفضل علاج لمشكلتي الطبية	0	1	2	3	4	5
12	كان لدي وقت كافٍ لأسأل الطبيب كل ما أردت معرفته	0	1	2	3	4	5
13	أجاب الطبيب على جميع أسئلتي	0	1	2	3	4	5
14	شجعني الطبيب للحديث عن مخاوفي	0	1	2	3	4	5
15	شعرت أن الطبيب لم يفهم ما قلته، لأنه لا يتحدث لغتي	0	1	2	3	4	5
16	هنالك أمور أمكن أن تكون أفضل في زيارتي للطبيب	0	1	2	3	4	5
17	أريد الحصول على معلومات إضافية عن مشكلتي الطبية من الأقارب	0	1	2	3	4	5
18	أريد أن يشاركني الطبيب في القرار المتعلق بطريقة علاج مشكلتي الطبية	0	1	2	3	4	5
19	تحدث الطبيب بصورة واضحة وفهمت ما قاله لي	0	1	2	3	4	5
20	شعرت أن الطبيب على عجلة	0	1	2	3	4	5
21	شجعني الطبيب على طرح أسئلة	0	1	2	3	4	5
22	أريد أن أسأل عائلتي فيما يخص علاج مشكلتي الطبية	0	1	2	3	4	5

بأي مدى توافق مع كل واحدة من الجمل التالية؟		لا علاقة بالموضوع	لا أوافق أبداً	أوافق بدرجة قليلة	أوافق بدرجة متوسطة	أوافق بدرجة كبيرة	أوافق بدرجة كبيرة جداً
23	شرح لي الطبيب بكلمات لم أفهمها	0	1	2	3	4	5
24	كنت أفضل أن يخصص لي الطبيب وقتاً أطول	0	1	2	3	4	5
25	كان الطبيب هو المتحدث خلال معظم وقت الزيارة	0	1	2	3	4	5
26	أريد أن أشارك بالقرار بخصوص علاجي بشكل أعمق مما سمح به الطبيب	0	1	2	3	4	5
27	تكبّر الطبيب علي أحياناً	0	1	2	3	4	5
28	أشعر براحة أكبر حين أتحدث عن مشاكل عاطفية مع طبيبة	0	1	2	3	4	5
29	سمح لي الطبيب بقول كل ما أردته	0	1	2	3	4	5
30	كنت أفضل أن يفحصني طبيب	0	1	2	3	4	5
31	أنا والطبيب تمازحنا وضحكنا خلال الزيارة	0	1	2	3	4	5
32	قام الطبيب بشرح مشكلتي الطبية بشكل واضح	0	1	2	3	4	5
33	أريد أن أسأل الرابي/الشيخ/الكاهن حول علاج مشكلتي	0	1	2	3	4	5
34	أنا راض عن العلاج الطبي الذي تلقيته من الطبيب	0	1	2	3	4	5
35	الوقت الذي خُصص لي عند الطبيب كان قصيراً	0	1	2	3	4	5
36	قام الطبيب بشرح الإمكانيات المختلفة المتعلقة بعلاج مشكلتي الطبية	0	1	2	3	4	5
37	أريد معلومات إضافية حول مشكلتي الطبية بواسطة البحث بشبكة الإنترنيت	0	1	2	3	4	5
38	شعرت أني بحتاجة لمترجم خلال الزيارة	0	1	2	3	4	5
39	عاملني الطبيب بتقدير وإحترام	0	1	2	3	4	5
40	أصغى الطبيب لكل ما قلته	0	1	2	3	4	5
41	شعرت أن الطبيب يفهمني حقاً	0	1	2	3	4	5
42	أريد إستشارة الأصدقاء بخصوص علاج مشكلتي الطبية	0	1	2	3	4	5
43	أحتاج لوقت أكبر لكي أتعرف على الطبيب قبل أن أحدثه عن مشكلتي الطبية	0	1	2	3	4	5
44	بعد المحادثة مع الطبيب فإنني أفهم كل شيء عن مشكلتي الطبية	0	1	2	3	4	5
45	كنت أفضل أن يترجم لي خلال زيارتي شخص ليس من أقربائي	0	1	2	3	4	5
46	إهتم الطبيب بعائلتي وحالتي الشخصية	0	1	2	3	4	5
47	أشعر براحة أكبر حين أتحدث مع طبيب عن مشاكلي الطبية	0	1	2	3	4	5
48	أنا راض من زيارتي للطبيب	0	1	2	3	4	5

Questionnaire in Russian

Анкета-соглашение участвовать в опросе.

Мы проводим исследование мнения пациентов относительно медицинского обслуживания (лечения). Исследование проводится анонимным путём.
Мы просим Вас заполнить краткую анкету с целью узнать Ваше мнение.
В случае, если Вы согласны принять участие в опросе, просим заполнить нижеследующие приложения.

Я, нижеподписавшийся/аяся:

Имя и фамилия:	
Номер удостоверения личности:	

а) заявляю, что я согласен/на участвовать в исследовании, в рамках вышеизложенного.
б) заявляю, что мне объяснили:

Имя объяснившего:

4. что я могу не участвовать в исследовании или же прекратить моё участие в
в исследовании в любое время;
2. мне гарантированно, что мои личные данные будут сохранены в полной секретности теми, кто занимается этим исследованием и не будут опубликованы
ни в каком издании, включая научные работы.

Заявление исследователя / его помощников / дающего объяснение:

Это соглашение было получено мною после того, как я объяснил участнику/це исследования всё вышесказанное и удостоверился, что он/а понял/а все мои объяснения.

Имя объяснившего:	Подпись:	Дата:

Здравствуйте!

Анкета, представленная перед Вами, составлена в рамках исследования мнения пациентов относительно медицинского обслуживания (лечения).

Исследование проводится анонимным путём, и Вы не обязаны указывать Ваше имя и другие личные данные в анкете. Ваши ответы будут сохранены в полной секретности у составителей анкеты и использованы только для статистических целей.

У больницы и медицинского персонала не будет возможности узнать ответы каждого пациента.

На все вопросы нет правильных или неправильных ответов. Мы заинтересованны узнать Ваше мнение.

Просим Вас ответить на вопросы в связи с посещением врача **сегодня**.

Из соображений более удобной обработки анкет, вопросы анкеты сформулированы в мужском роде. В связи с этим, приносим Вам свои извинения.

В анкете, представленной Вам, ответы распределены по ступеням от 0 до 5:

1- совершенно не согласен;
2- согласен в небольшой степени;
3- согласен в средней степени;
4-согласен в большой степени;
5- полностью согласен.

Пожалуйста, обозначьте **x** в графе, соответствующей Вашему мнению.

1. Год рождения: _____
2. Год приезда в Израиль: _____ 3. Место рождения: _____

4. Пол: □[1] мужской □[2] женский

5. Семейное положение: □[1] холост □[2] женат □[3] разведен □[4] вдовец □[5] расстались □[6] другое

6. Религия: [1] иудей □[2] мусульманин □[3] христианин □[4] друг □[5] другое

7. Сколько лет образования: _____

8. Степень владения ивритом:
□[1] совсем нет □[2] немного □[3] средняя □[4] хорошая □[5] очень хорошая

9. Пришли ли вы на посещение сами: □[1] да □[2] нет

Если нет, кто вас сопровождал? □[1] отец □[2] мать □[3] брат □[4] сестра □[5] муж □[6] жена □[7] дочь □[8] сын □[9] другой родственник □[10] знакомый □[11] другое

10. На каком языке говорили во время посещения □[1] иврит □[2] арабский □[3] русский

11. Переводил ли кто-нибудь во время посещения? □[1] да □[2] нет

Если да, кто переводил? □[1] отец □[2] мать □[3] брат V[4] сестра □[5] муж □[6] жена □[7] дочь □[8] сын □[9] другой родственник □[10] знакомый □[11] медицинский персонал □[12] другие

12. Посещение было проведено у врача: □[1] мужского пола □[2] женского

В какой мере вы согласны с каждым из этих пунктов?		Не относится к вопросу	Совершенно не согласен	Согласен в небольшой степен	Согласен в средней степен	Согласен в больш ой степеи	Полностью согласен
1.	Врач объяснил мне всё, что я хотел знать о моей медицинской проблеме и о возможности её лечения	0	1	2	3	4	5
2.	Врач объяснил мне его планы относительно моего лечения	0	1	2	3	4	5
3.	Я чувствовал, что могу говорить с врачом о личных проблемах	0	1	2	3	4	5
4.	Я не понял всё, что врач мне сказал, потому что он не говорил на моём языке	0	1	2	3	4	5
5.	Врач хотел чтоб я участвовал в решении возможностей моего лечения	0	1	2	3	4	5
6.	Я бы предпочел, чтобы врач была женского пола	0	1	2	3	4	5
7.	Врач часто прерывал меня во время нашей беседы	0	1	2	3	4	5
8.	Мне важно, чтобы врач объяснил мне всё о моей медицинской проблеме и о методе лечения	0	1	2	3	4	5
9.	Я бы предпочел, чтобы врач говорил на моём языке	0	1	2	3	4	5
10.	Я чувствовал, что врач интересуется мной, как человеком	0	1	2	3	4	5
11.	Я хочу, чтобы врач решил за меня какое лечение лучше для моей медицинской проблемы	0	1	2	3	4	5
12.	У меня было достаточно времени, чтобы спросить врача всё, что я хотел знать	0	1	2	3	4	5
13.	Врач ответил на все мои вопросы	0	1	2	3	4	5
14.	Врач стимулировал меня говорить о волнующих меня проблемах	0	1	2	3	4	5
15.	Я чувствовал, что врач не понял то, что я ему сказал из-за того, что он не говорит на моём языке	0	1	2	3	4	5
16.	Несколько вещей можно было бы улучшить во время моего посещении врача	0	1	2	3	4	5
17.	Я хочу получить дополнительную информацию о моей медицинской проблеме от родственников	0	1	2	3	4	5
18.	Я хочу, чтобы врач присоединил меня к участию в решении относительно моего лечения	0	1	2	3	4	5

В какой мере вы согласны с каждым из этих пунктов?		Не относится к вопросу	Совершенно не согласен	Согласен в небольшой степени	Согласен в средней степени	Согласен в больш ой степеи	Полностью согласен
19.	Врач говорил понятно и я понял, что он мне сказал	0	1	2	3	4	5
20.	Я чувствовал, что врач торопится	0	1	2	3	4	5
21.	Врач стимулировал меня задавать вопросы	0	1	2	3	4	5
22.	Я хочу посоветоваться с моей семьей относительно лечения моей медицинской проблемы	0	1	2	3	4	5
23.	Врач объяснял мне непонятными словами	0	1	2	3	4	5
24.	Я хочу, чтобы врач уделил мне больше времени	0	1	2	3	4	5
25.	Во время посещения большую часть времени говорил врач	0	1	2	3	4	5
26.	Я бы хотел быть вовлечен в участие в решении относительно моего лечения больше, чем врач мне позволил	0	1	2	3	4	5
27.	Иногда врач важничал и возвеличивался надо мной	0	1	2	3	4	5
28.	Я чувствую, что удобно больше говорить о волнующих меня проблемах с врачом	0	1	2	3	4	5
29.	Врач дал мне возможность сказать обо всём, что я хотел	0	1	2	3	4	5
30.	Я бы предпочел, чтобы врач был мужского пола	0	1	2	3	4	5
31.	Врач и я смеялись и шутили во время посещения	0	1	2	3	4	5
32.	Врач ясно объяснил мне мою медицинскую проблему	0	1	2	3	4	5
33.	Я хочу посоветоваться с раввином, священником или другим духовным лицом о лечении моей медицинской проблемы	0	1	2	3	4	5
34.	Я доволен медицинским обслуживанием при посещении врача	0	1	2	3	4	5
35.	Время, данное мне у врача, было недостаточным	0	1	2	3	4	5
36.	Врач объяснил мне разные возможности лечения моей медицинской проблемы	0	1	2	3	4	5
37.	Я хочу получить дополнительную информацию о моей медицинской проблеме из Интернета	0	1	2	3	4	5
38.	Я чувствовал во время посещения, что мне нужен переводчик	0	1	2	3	4	5
39.	Врач отнёсся ко мне с уважением и пониманием	0	1	2	3	4	5

В какой мере вы согласны с каждым из этих пунктов?		Не относится к вопросу	Совершенно не согласен	Согласен в небольшой степен	Согласен в средней степен	Согласен в больш ой степеи	Полностью согласен
40.	Врач выслушал всё, что я сказал	0	1	2	3	4	5
41.	Я чувствовал, что врач меня по-настоящему понял	0	1	2	3	4	5
42.	Я хочу посоветоваться с друзьями, относительно лечения моей медицинской проблемы	0	1	2	3	4	5
43.	Мне нужно больше времени, чтобы узнать врача, перед тем как я смогу рассказать ему о моей медицинской проблеме	0	1	2	3	4	5
44.	После беседы с врачом я понимаю всё о моей медицинской проблеме	0	1	2	3	4	5
45.	Я бы предпочел, чтобы кто-нибудь другой, а не мой родственник, переводил во время посещения	0	1	2	3	4	5
46.	Врач интересовался моей семьей и личной жизнью	0	1	2	3	4	5
47.	Я чувствую, что более удобно говорить о моих медицинских проблемах с врачом мужского пола	0	1	2	3	4	5
48.	Я доволен моим посещением врача	0	1	2	3	4	5

Questionnaire in English

Informed Consent Form

We are conducting research concerning patients' attitudes towards medical care. The study is anonymous, and we ask for your cooperation in answering a short questionnaire reflecting your attitudes.
If you agree to participate in the research and answer the questionnaire, please sign the following consent form.

I, the undersigned:

Name and Surname:	
ID No.:	

A) Declare that I agree to participate in the research as detailed in this document.
B) Declare that I was informed by

Name of interviewer:

1. That I am free to choose not to participate in the research, and that I am free to stop my participation at any time.
2. That I have been promised that my identity will be kept confidential by everyone involved in the research, and will not be published in any publication, including scientific publications.

Declaration of researcher / assistant researcher / interviewer:

I received the following consent after I explained to the participant in the research all the above mentioned and I confirmed that all my explanations were understood by him/her.

Name of Interviewer:	Signature:	Date:

Shalom

The following questionnaire is part of a research study concerning patients' attitudes towards medical care. The study is anonymous, and we ask you not to mention your name or other identifying details on the questionnaire forms.
Your answers will be confidential, will be kept in complete confidence by the researchers only, and will serve for statistical testing only. The hospital and medical staff will not have access to patients' answers.
In the following questionnaire there are no right answers. We are interested in your personal opinion. You are asked to refer your answers to your visit with the doctor today.
For convenience, masculine pronouns are used throughout the questionnaire.
In the following questionnaire the answers are arranged on a scale of 1 to 5: **1**=Totally Disagree, **2**=Agree Mildly, **3**=Agree Moderately, **4**=Agree Very Much, **5**=Agree Totally, 0=Irrelevant.

Please put an **X** next to the answer which best reflects your opinion.

1. Year of Birth: _____
2. Year of Immigration: _____ 3. Country of Birth: _____

4. Gender: □[1] Male □[2] Female

5. Marital Status: □[1] Single □[2] Married □[3] Divorced
□[4] Widowed □[5] Separated □[6] Other

6. Religion: □[1] Jewish □[2] Muslim □[3] Christian □[4] Druze □[5] Other

7. Years of Education: _____

8. Hebrew Language Proficiency:
□[1] None □[2] Poor □[3] Fair □[4] Good □[5] Very Good

9. Did you come alone to this doctor's visit? □[1] Yes □[2] No
If not, who accompanied you? □[1] Father □[2] Mother □[3] Brother □[4] Sister □[5] Husband □[6] Wife □[7] Daughter □[8] Son □[9] Other Family Member □[10] Friend □[11] Other
10. Language in which the visit was conducted: □[1] Hebrew □[2] Arabic □[3] Russian
11. Did someone translate during the visit? □[1] Yes □[2] No
If so, who translated? □[1] Father □[2] Mother □[3] Brother □[4] Sister □[5] Husband □[6] Wife □[7] Daughter □[8] Son □[9] Other Family Member □[10] Friend □[11] Medical Staff Member □[12] Other
12. The visit was with: □[1] A Male Doctor □[2] A Female Doctor

To what extent do you agree with each of the following sentences?		Irrele-vant	Totally Disagree	Agree Mildly	Agree Moder-ately	Agree Very Much	Agree Totally
1.	The doctor told me all I wanted to know about my medical condition and its treatment	0	1	2	3	4	5
2.	The doctor told me his/her plans for my treatment	0	1	2	3	4	5
3.	I felt able to tell this doctor about personal matters	0	1	2	3	4	5
4.	I did not understand everything the doctor told me, because he does not speak my language	0	1	2	3	4	5
5.	The doctor wanted me to share with him/her the decision about my treatment	0	1	2	3	4	5
6.	I prefer to be examined by a female doctor	0	1	2	3	4	5
7.	The doctor interrupted me frequently during our conversation	0	1	2	3	4	5
8.	It important to me that the doctor tell me everything about my medical condition and treatment	0	1	2	3	4	5
9.	I would prefer to be examined by a doctor who speaks my language	0	1	2	3	4	5
10.	The doctor seemed interested in me as a person	0	1	2	3	4	5
11.	I want my doctor to decide what the best treatment is for my medical condition	0	1	2	3	4	5
12.	I had enough time to ask the doctor all I wanted to know	0	1	2	3	4	5
13.	The doctor answered all my questions	0	1	2	3	4	5
14.	The doctor encouraged me to talk about my concerns	0	1	2	3	4	5
15.	I felt that the doctor did not understand everything I told him because he does not speak my language	0	1	2	3	4	5
16.	Some things during my consultation with the doctor could have been better	0	1	2	3	4	5
17.	I want to get more information about my medical condition and treatment from my relatives	0	1	2	3	4	5
18.	I want the doctor to involve me in the decision of choosing the treatment for my medical condition	0	1	2	3	4	5
19.	The doctor spoke clearly and I understood what he told me	0	1	2	3	4	5
20.	The doctor seemed to be in a hurry	0	1	2	3	4	5
21.	The doctor encouraged me to ask questions	0	1	2	3	4	5
22.	I want to consult my family regarding the treatment for my medical condition	0	1	2	3	4	5
23.	The doctor explained things in words I could not understand	0	1	2	3	4	5
24.	I would have liked to spend more time with the doctor	0	1	2	3	4	5
25.	The doctor did most of the talking during the visit	0	1	2	3	4	5

To what extent do you agree with each of the following sentences?		Irrele-vant	Totally Disagree	Agree Mildly	Agree Moder-ately	Agree Very Much	Agree Totally
26.	I want to be more involved in the decision regarding my treatment than the doctor let me	0	1	2	3	4	5
27.	Sometimes the doctor talked down on me	0	1	2	3	4	5
28.	I feel more comfortable talking about emotional problems with a female doctor	0	1	2	3	4	5
29.	The doctor gave me a chance to say everything that was on my mind	0	1	2	3	4	5
30.	I prefer to be examined by a male doctor	0	1	2	3	4	5
31.	The doctor and I laughed and joked together during the visit	0	1	2	3	4	5
32.	The doctor clearly explained my medical condition	0	1	2	3	4	5
33.	I want to consult my Rabbi / Sheik / Priest about the treatment for my medical condition	0	1	2	3	4	5
34.	I am satisfied with the medical treatment I received from the doctor	0	1	2	3	4	5
35.	The time I was able to spend with the doctor was too short	0	1	2	3	4	5
36.	The doctor discussed the options for my treatment with me	0	1	2	3	4	5
37.	I want to get more information about my medical condition by searching the Internet	0	1	2	3	4	5
38.	I felt the need for someone to translate during the visit	0	1	2	3	4	5
39.	The doctor treated me with dignity and respect	0	1	2	3	4	5
40.	The doctor listened carefully to everything I said	0	1	2	3	4	5
41.	I felt the doctor really understood me	0	1	2	3	4	5
42.	I want to consult my friends about the treatment for my medical condition	0	1	2	3	4	5
43.	I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition	0	1	2	3	4	5
44.	After talking to the doctor, I understand everything about my medical condition	0	1	2	3	4	5
45.	I would have liked someone else other than my family member translate in the visit	0	1	2	3	4	5
46.	The doctor asked me about my family and my personal life	0	1	2	3	4	5
47.	I feel more comfortable talking about my medical problems with a male doctor	0	1	2	3	4	5
48.	I am satisfied with my visit to the doctor	0	1	2	3	4	5

Appendix C2: Questionnaires in Hebrew, Arabic, Russian, English - pre-test No. 2

Questionnaire in Hebrew (The first two parts of the questionnaire remained unchanged as in pre-test No.1)

	באיזו מידה אתה מסכים עם כל אחד מהמשפטים הבאים?	כלל לא	במידה מועטה	במידה בינונית	במידה רבה	במידה רבה מאד
.1	הרופא הסביר לי כל מה שרציתי לדעת על הבעיה הרפואית שלי ועל דרך הטיפול	1	2	3	4	5
.2	הרופא הסביר לי על תוכניותיו לגבי הטיפול שלי	1	2	3	4	5
.3	הרגשתי שאני יכול לדבר עם הרופא על עניינים אישיים	1	2	3	4	5
.4	הרופא רצה לשתף אותי בקבלת ההחלטה על הטיפול שלי	1	2	3	4	5
.5	חשוב לי שהרופא יסביר לי הכל על הבעיה הרפואית שלי ועל דרך הטיפול	1	2	3	4	5
.6	אני מעדיף להיות מטופל ע"י רופא שמדבר את השפה שלי	1	2	3	4	5
.7	הרגשתי שהרופא מתעניין בי כבן אדם	1	2	3	4	5
.8	אני רוצה שהרופא יחליט בשבילי מה הטיפול הטוב ביותר עבור הבעיה הרפואית שלי	1	2	3	4	5
.9	היה לי מספיק זמן כדי לשאול את הרופא את כל מה שרציתי לדעת	1	2	3	4	5
.10	הרופא ענה על כל השאלות שלי	1	2	3	4	5
.11	הרופא עודד אותי לדבר על הדאגות שלי	1	2	3	4	5
.12	יש מספר דברים שיכלו להיות טובים יותר בביקור שלי אצל הרופא	1	2	3	4	5
.13	אני רוצה לקבל מידע נוסף על הבעיה הרפואית שלי מקרובי משפחה	1	2	3	4	5
.14	אני רוצה להחליט ביחד עם הרופא על הטיפול בבעיה הרפואית שלי	1	2	3	4	5
.15	הרופא דבר בשפה ברורה והבנתי את מה שהוא אמר לי	1	2	3	4	5
.16	הרגשתי שהרופא ממהר	1	2	3	4	5
.17	הרופא עודד אותי לשאול שאלות	1	2	3	4	5
.18	אני רוצה להתייעץ עם המשפחה שלי בקשר לטיפול בבעיה הרפואית שלי	1	2	3	4	5
.19	הרופא נתן לי הסברים במילים שלא הבנתי	1	2	3	4	5
.20	הייתי רוצה שהרופא יקדיש לי יותר זמן	1	2	3	4	5
.21	הרופא היה זה שדבר ברוב זמן הביקור	1	2	3	4	5
.22	הייתי רוצה להיות מעורב בהחלטה על הטיפול שלי יותר מכפי שהרופא אפשר לי	1	2	3	4	5
.23	הרופא אפשר לי להגיד כל מה שרציתי	1	2	3	4	5
.24	הרופא ואני צחקנו והתבדחנו בזמן הביקור	1	2	3	4	5
.25	בבעיות רפואיות כדאי להתייעץ עם איש דת (רב / שייך/ כומר)	1	2	3	4	5
.26	אני שבע רצון מהטיפול הרפואי שקבלתי אצל הרופא	1	2	3	4	5

	באיזו מידה אתה מסכים עם כל אחד מהמשפטים הבאים?	כלל לא	במידה מועטה	במידה בינונית	במידה רבה	במידה רבה מאד
.27	הזמן שניתן לי אצל הרופא היה קצר מדי	1	2	3	4	5
.28	הרופא הסביר לי את האפשרויות השונות לטיפול בבעיה הרפואית שלי	1	2	3	4	5
.29	הרופא הזה מתייחס בהערכה ובכבוד למטופלים שלו	1	2	3	4	5
.30	הרגשתי שהרופא באמת מבין אותי	1	2	3	4	5
.31	בבעיות רפואיות כדאי להתייעץ גם עם חברים	1	2	3	4	5
.32	אני צריך זמן כדי להכיר את הרופא, לפני שאני יכול לספר לו על הבעיה הרפואית שלי	1	2	3	4	5
.33	בעקבות השיחה עם הרופא אני מבין הכל על הבעיה הרפואית שלי	1	2	3	4	5
.34	הרופא התעניין במשפחה שלי ובחיי הפרטיים	1	2	3	4	5
.35	אני שבע רצון מהיחס של הרופא כלפי	1	2	3	4	5
.36	הרופא הפסיק אותי לפעמים בזמן השיחה שלנו	1	2	3	4	5

37. אני מעדיף להיבדק ע"י □[1] רופא □[2] רופאה □[3] לא חשוב לי

38. אני מרגיש נוח יותר לשוחח על הבעיות הרפואיות שלי עם

□[1] רופא □[2] רופאה □[3] לא חשוב לי

39. אני מרגיש נוח יותר לדבר על הבעיות הרגשיות שלי עם

□[1] רופא □[2] רופאה □[3] לא חשוב לי

40. אני נוהג לחפש מידע נוסף על הבעיות הרפואיות שלי באינטרנט

□[1] כן □[2] לא □[3] אחר

נא למלא רק אם היו בעיות שפה בביקור שלך היום אצל הרופא

	באיזו מידה אתה מסכים עם כל אחד מהמשפטים הבאים?	כלל לא	במידה מועטה	במידה בינונית	במידה רבה	במידה רבה מאד
.41	לא הבנתי את כל מה שהרופא אמר לי, כי הוא לא מדבר את השפה שלי	1	2	3	4	5
.42	הרגשתי שהרופא לא הבין את מה שאמרתי לו, כי הוא לא מדבר את השפה שלי	1	2	3	4	5
.43	הרגשתי שאני זקוק למישהו שיתרגם בזמן הביקור	1	2	3	4	5
.44	הייתי מעדיף שמישהו אחר, ולא בן משפחה שלי, יתרגם בזמן הביקור	1	2	3	4	5

Questionnaire in Arabic (The first two parts of the questionnaire remained unchanged as in pre-test No.1)

	بأي مدى توافق مع كل واحدة من الجمل التالية؟	لا أوافق أبداً	أوافق بدرجة قليلة	أوافق بدرجة متوسطة	أوافق بدرجة كبيرة	أوافق بدرجة كبيرة جداً
1	لقد شرح لي الطبيب جميع ما أردت أن أعرفه عن مشكلتي الطبية وطريقة علاجها	1	2	3	4	5
2	شرح لي الطبيب مخططاته المتعلقة بعلاجي	1	2	3	4	5
3	شعرت أني أستطيع الحديث مع الطبيب حول مواضيع شخصية	1	2	3	4	5
4	أراد الطبيب إشراكي في إتخاذ القرار حول طريقة علاجي	1	2	3	4	5
5	من المهم بالنسبة لي أن يشرح لي الطبيب كل شيء بخصوص مشكلتي الطبية وطريقة علاجها	1	2	3	4	5
6	كنت أفضل أن يفحصني طبيب يتحدث لغتي	1	2	3	4	5
7	شعرت أن الطبيب مهتم بي كإنسان	1	2	3	4	5
8	أريد أن يقرر الطبيب من أجلي أفضل علاج لمشكلتي الطبية	1	2	3	4	5
9	كان لدي وقت كافٍ لأسأل الطبيب كل ما أردت معرفته	1	2	3	4	5
10	أجاب الطبيب على جميع أسئلتي	1	2	3	4	5
11	شجعني الطبيب للحديث عن مخاوفي	1	2	3	4	5
12	هنالك أمور أمكن أن تكون أفضل في زيارتي للطبيب	1	2	3	4	5
13	أريد الحصول على معلومات إضافية عن مشكلتي الطبية من الأقارب	1	2	3	4	5
14	أريد أن اقرر سويا مع الطبيب طريقة علاج مشكلتي الطبية	1	2	3	4	5
15	تحدث الطبيب بلغه واضحة وفهمت ما قاله لي	1	2	3	4	5
16	شعرت أن الطبيب على عجلة	1	2	3	4	5
17	شجعني الطبيب على طرح أسئلة	1	2	3	4	5
18	أريد أن أسأل عائلتي فيما يخص علاج مشكلتي الطبية	1	2	3	4	5
19	شرح لي الطبيب بكلمات لم أفهمها	1	2	3	4	5
20	كنت أفضل أن يخصص لي الطبيب وقتاً أطول	1	2	3	4	5
21	كان الطبيب هو المتحدث خلال معظم وقت الزيارة	1	2	3	4	5
22	كنت أريد أن أشارك بالقرار بخصوص علاجي بشكل أعمق مما سمح به الطبيب	1	2	3	4	5
23	سمح لي الطبيب بقول كل ما أردته	1	2	3	4	5
24	أنا والطبيب تمازحنا وضحكنا خلال الزيارة	1	2	3	4	5
25	بالمشاكل الطبيه محبذ استشارة رجل دين (الرابي/الشيخ/الكاهن)	1	2	3	4	5
26	أنا راضٍ عن العلاج الطبي الذي تلقيته من الطبيب	1	2	3	4	5
27	الوقت الذي خُصص لي عند الطبيب كان قصيراً	1	2	3	4	5
28	قام الطبيب بشرح الإمكانيات المختلفة المتعلقة بعلاج مشكلتي الطبية	1	2	3	4	5
29	هذا الطبيب يعامل بتقدير واحترام متعالجينه	1	2	3	4	5
30	شعرت أن الطبيب يفهمني حقاً	1	2	3	4	5
31	بالمشاكل الطبية محبذ الاستشارة ايضا مع اصدقاء	1	2	3	4	5

	بأي مدى توافق مع كل واحدة من الجمل التالية؟	لا أوافق أبدا	أوافق بدرجة قليلة	أوافق بدرجة متوسطة	أوافق بدرجة كبيرة	أوافق بدرجة كبيرة جدا
32	أحتاج لوقت أكبر لكي أتعرف على الطبيب قبل أن أحدثه عن مشكلتي الطبية	1	2	3	4	5
33	بعد المحادثة مع الطبيب فإنني أفهم كل شيء عن مشكلتي الطبية	1	2	3	4	5
34	إهتم الطبيب بعائلتي وحياتي الشخصية	1	2	3	4	5
35	انا راض من معاملة الطبيب تجاهي	1	2	3	4	5
36	احيانا قام الطبيب بايقافي عن الحديث خلال محادثتنا	1	2	3	4	5

37. انا افضل ان يفحصني □[1] طبيب □[2] طبيبة □[3] لا يهمني

38. اشعر براحة اكبر حين اتحدث عن مشاكلي الطبية

□[1] طبيب □[2] طبيبة □[3] لا يهمني

39. اشعر براحة اكبر حين اتحدث عن امور المتعلقة بمشاعري الداخلية

□[1] طبيب □[2] طبيبة □[3] لا يهمني

40. انا معتاد ان ابحث عن معلومات اضافية حول مشاكلي الطبية بواسطة الانترنت

□[1] نعم □[2] كلا □[3] آخر

ارجو التعبئة فقط ان كانت هناك مشاكل باللغة في الزيارة التي قمت بها اليوم لدى الطبيب

	بأي مدى توافق مع كل واحدة منالجمل التالية؟	لا أوافق أبدا	أوافق بدرجة قليلة	أوافق بدرجة متوسطة	أوافق بدرجة كبيرة	أوافق بدرجة كبيرة جدا
41	لم أفهم جميع ما قاله الطبيب، لأنه لم يتحدث لغتي	1	2	3	4	5
42	شعرت أن الطبيب لم يفهم ما قلته، لأنه لا يتحدث لغتي	1	2	3	4	5
43	شعرت أني بحاجة لمترجم خلال الزيارة	1	2	3	4	5
44	كنت أفضل أن يترجم لي خلال زيارتي شخص ليس من أقربائي	1	2	3	4	5

Questionnaire in Russian (The first two parts of the questionnaire remained unchanged as in pre-test No.1)

В какой мере вы согласны с каждым из этих пунктов?		**Совершенно не согласен**	**Согласен в небольшой степени**	**Согласен в средней степени**	**Согласен в больш ой степеи**	**Полностью согласен**
1.	Врач объяснил мне всё, что я хотел знать о моей медицинской проблеме и о возможности её лечения	1	2	3	4	5
2.	Врач объяснил мне его планы относительно моего лечения	1	2	3	4	5
3.	Я чувствовал, что могу говорить с врачом о личных проблемах	1	2	3	4	5
4.	Врач хотел чтоб я участвовал в решении возможностей моего лечения	1	2	3	4	5
5.	Мне важно, чтобы врач объяснил мне всё о моей медицинской проблеме и о методе лечения	1	2	3	4	5
6.	Я бы предпочел, чтобы врач говорил на моём языке	1	2	3	4	5
7.	Я чувствовал, что врач интересуется мной, как человеком	1	2	3	4	5
8.	Я хочу, чтобы врач решил за меня какое лечение лучше для моей медицинской проблемы	1	2	3	4	5
9.	У меня было достаточно времени, чтобы спросить врача всё, что я хотел знать	1	2	3	4	5
10.	Врач ответил на все мои вопросы	1	2	3	4	5
11.	Врач стимулировал меня говорить о волнующих меня проблемах	1	2	3	4	5
12.	Несколько вещей можно было бы улучшить во время моего посещения врача	1	2	3	4	5
13.	Я хочу получить дополнительную информацию о моей медицинской проблеме от родственников	1	2	3	4	5
14.	Я хочу вместе с врачом принять решение относительно моего лечения.	1	2	3	4	5
15.	Врач говорил на понятном языке и я понял то, что он мне сказал	1	2	3	4	5
16.	Я чувствовал, что врач торопится	1	2	3	4	5
17.	Врач стимулировал меня задавать вопросы	1	2	3	4	5
18.	Я хочу посоветоваться с моей семьей относительно лечения моей медицинской проблемы	1	2	3	4	5
19.	Врач объяснял мне непонятными словами	1	2	3	4	5
20.	Я хочу, чтобы врач уделил мне больше времени	1	2	3	4	5
21.	Во время посещения большую часть времени говорил врач	1	2	3	4	5
22.	Я бы хотел быть вовлечен в участие в решении относительно моего лечения больше, чем врач мне позволил	1	2	3	4	5
23.	Врач дал мне возможность сказать обо всём, что я хотел	1	2	3	4	5
24.	Врач и я смеялись и шутили во время посещения	1	2	3	4	5

В какой мере вы согласны с каждым из этих пунктов?		**Совершенно не согласен**	**Согласен в небольшой степени**	**Согласен в средней степени**	**Согласен в больш ой степени**	**Полностью согласен**
25.	Имеет смысл посоветоваться по поводу меди- цинских проблем с духовным лицом (равви- ном, священником или другим духовным лицом).	1	2	3	4	5
26.	Я доволен медицинским обслуживанием, полученным во время посещения врача	1	2	3	4	5
27.	Время, данное мне у врача, было недостаточным	1	2	3	4	5
28.	Врач объяснил мне разные возможности лечения моей медицинской проблемы	1	2	3	4	5
29.	Врач относиться с уважением и пониманием к его пациентам	1	2	3	4	5
30.	Я чувствовал, что врач меня по-настоящему понял	1	2	3	4	5
31.	Имеет смысл посоветоваться по поводу медицинских проблем также и с друзьями.	1	2	3	4	5
32.	Мне нужно больше времени, чтобы узнать врача, перед тем как я смогу рассказать ему о моей медицинской проблеме	1	2	3	4	5
33.	После беседы с врачом я понимаю всё о моей медицинской проблеме	1	2	3	4	5
34.	Врач интересовался моей семьей и личной жизнью	1	2	3	4	5
35.	Я доволен отношением врача ко мне.	1	2	3	4	5
36.	Врач иногда прерывал меня во время нашей беседы.	1	2	3	4	5

37. Я предпочитаю пройти проверку у врача:

□ мужского пола □ женского пола □ не имеет значения

38. Я чувствую, что более удобно беседовать о моих медицинских проблемах с врачом:

□[1] мужского пола □[2] женского пола □[3] не имеет значения

39. Я чувствую, что более удобно говорить о волнующих меня проблемах с врачом:

□[1] мужского пола □[2] женского пола □[3] не имеет значения

40. Я, как правило, ищу дополнительную информацию о моей медицинской проблеме в Интернете.

□[1] да □[2] нет □[3] другое

Пожалуйста заполнить только в том случае, если были проблемы, связанные с языком при сегодняшнем посещении врача.

В какой мере вы согласны с каждым из этих пунктов?		**Совершенно не согласен**	**Согласен в небольшой степени**	**Согласен в средней степени**	**Согласен в большой степени**	**Полностью согласен**
41.	Я не понял всё, что врач мне сказал, потому что он не говорил на моём языке	1	2	3	4	5
42.	Я чувствовал, что врач не понял то, что я ему сказал из-за того, что он не говорит на моём языке	1	2	3	4	5
43.	Я чувствовал во время посещения, что мне нужен переводчик	1	2	3	4	5
44.	Я бы предпочел, чтобы кто-нибудь другой, а не мой родственник, переводил во время посещения	1	2	3	4	5

Questionnaire in English (The first two parts of the questionnaire remained unchanged as in pre-test No.1)

To what extent do you agree with each of the following sentences?		Totally disagree	Agree mildly	Agree moderately	Agree very much	Agry totally
1.	The doctor told me all I wanted to know about my medical condition and its treatment	1	2	3	4	5
2.	The doctor told me his/her plans for my treatment	1	2	3	4	5
3.	I felt able to tell this doctor about personal things	1	2	3	4	5
4.	The doctor wanted me to share with him/her the decision about my treatment	1	2	3	4	5
5.	It important that the doctor tell me everything about my medical condition and treatment	1	2	3	4	5
6.	I prefer to be examined by a doctor who speaks my language	1	2	3	4	5
7.	The doctor seemed interested in me as a person	1	2	3	4	5
8.	I want my doctor to decide what the best treatment is for my medical condition	1	2	3	4	5
9.	I had enough time to ask the doctor all I wanted to know	1	2	3	4	5
10.	The doctor answered all my questions	1	2	3	4	5
11.	The doctor encouraged me to talk about my concerns	1	2	3	4	5
12.	Some things about my consultation with the doctor could have been better	1	2	3	4	5
13.	I want to get more information about my medical condition and treatment from my relatives	1	2	3	4	5
14.	I want to decide together with the doctor about the treatment for my medical problem	1	2	3	4	5
15.	The doctor used clear language and I understood what he told me	1	2	3	4	5
16.	The doctor seemed to be in a hurry	1	2	3	4	5
17.	The doctor encouraged me to ask questions	1	2	3	4	5
18.	I want to consult my family regarding the treatment for my medical condition	1	2	3	4	5
19.	The doctor explained things in words I could not understand	1	2	3	4	5
20.	I would have liked to spend more time with the doctor	1	2	3	4	5
21.	The doctor did most of the talking during the visit	1	2	3	4	5
22.	I want to be more involved in the decision regarding my treatment than the doctor let me	1	2	3	4	5
23.	The doctor gave me a chance to say everything that was on my mind	1	2	3	4	5
24.	The doctor and I laughed and joked together during the visit	1	2	3	4	5
25.	For medical problems, it's a good idea to consult a clergyman (Rabbi / Sheikh / Priest)	1	2	3	4	5
26.	I am satisfied with the medical treatment I received from the doctor	1	2	3	4	5

To what extent do you agree with each of the following sentences?		Totally disagree	Agree mildly	Agree moderately	Agree very much	Agry totally
27.	The time I was able to spend with the doctor was too short	1	2	3	4	5
28.	The doctor discussed the options for my treatment with me	1	2	3	4	5
29.	This doctor treats his patients with dignity and respect	1	2	3	4	5
30.	I felt the doctor really understood me	1	2	3	4	5
31.	For medical problems, it's a good idea to consult friends.	1	2	3	4	5
32.	I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition	1	2	3	4	5
33.	After talking to the doctor, I understand everything about my medical condition	1	2	3	4	5
34.	The doctor was interested in my family and my personal life	1	2	3	4	5
35.	I am satisfied with the physician's courtesy towards me	1	2	3	4	5
36.	The doctor interrupted me sometimes during our conversation	1	2	3	4	5

37. I would prefer to be examined by:

□[1] A male physician □[2] A female physician □[3] No preference

38. I feel more comfortable talking about my medical problems with:

□[1] A male physician □[2] A female physician □[3] No preference

39. I feel more comfortable talking about my emotional problems with:

□[1] A male physician □[2] A female physician □[3] No preference

40. I search the internet for more information about my medical problems

□[1] Yes □[2] No □[3] Other

Please fill out the following only if you had language problems during your visit with the physician today

To what extent do you agree with each of the following sentences?		Totally disagree	Agree mildly	Agree Moderately	Agree Very much	Agree totally
41.	I did not understand everything the doctor told me, because he does not speak my language	1	2	3	4	5
42.	I felt that the doctor did not understand everything I told him because he does not speak my language	1	2	3	4	5
43.	I felt the need for someone to translate during the visit	1	2	3	4	5
44.	I would have liked someone else other than my family member to translate during the visit	1	2	3	4	5

Appendix D: Questionnaire statements divided into sub-scales (numbers refer to statement numbers in the questionnaire)

a. Information-giving and seeking

1. The doctor told me all I wanted to know about my medical condition and its treatment. (1)
2. The doctor told me his/her plans for my treatment. (2)
3. It is important to me that the doctor tell me everything about my medical condition and treatment. (5)
4. The doctor answered all my questions. (10)
5. The doctor was the one who did most of the talking during the visit. (21)
6. The doctor gave me a chance to say everything that was on my mind. (23)
7. The doctor discussed the options for my treatment with me. (28)
8. After talking to the doctor, I understand everything about my medical condition. (33)

b. Participatory decision-making

1. I want my doctor to decide what the best treatment is for my medical condition. (8)
2. I want to decide together with the doctor about the treatment for my medical problem. (14)
3. I want to be more involved in the decision regarding my treatment than the doctor let me. (22)

c. Consulting with others

1. I want to get more information about my medical condition and treatment from my relatives. (13)
2. I want to consult my family regarding the treatment for my medical condition. (18)
3. It's a good idea to consult a religious clergyman (Rabbi/Sheikh/Priest) regarding medical problems. (25)
4. It's a good idea to consult friends regarding medical problems. (31)

d. Verbal communication

1. The doctor used clear language and I understood what he told me. (15)
2. The doctor explained things in words I could not understand. (19)
3. I did not understand everything the doctor told me, because he/she does not speak my language. (41)
4. I felt that the doctor did not understand everything I told him because he does not speak my language. (42)
5. I felt the need for someone to translate during the visit. (43)
6. I would have liked someone else other than my family member to translate during the visit. (44)

e. Time

1. I had enough time to ask the doctor all I wanted to know. (9)
2. The doctor seemed to be in a hurry. (16)
3. I would have liked to spend more time with the doctor. (20)
4. The time I was able to spend with the doctor was short. (27)
5. The doctor interrupted me sometimes during our conversation. (36)

f. Physician's interpersonal communication

1. I felt able to tell this doctor about personal things. (3)
2. The doctor seemed interested in me as a person. (7)
3. The doctor encouraged me to talk about my concerns. (11)
4. The doctor and I laughed and joked together during the visit. (24)
5. This doctor treats his/her patients with dignity and respect. (29)
6. I felt the doctor really understood me. (30)
7. The doctor was interested in my family and my personal life. (34)

g. Gender

1. I would prefer to be examined by: A male physician/ a female physician/ No preference. (37)
2. I feel more comfortable talking about my medical problems with:
   a male physician/ a female physician/ No preference. (38)
3. I feel more comfortable talking about emotional problems with:
   A male physician/ a female physician/ No preference. (39)

h. Statements which were examined separately:

1. The doctor wanted me to share with him/her the decision about my treatment. (4)
2. I prefer to be examined by a doctor who speaks my language. (6)
3. Some things about my consultation with the doctor could have been better. (12)
4. I am satisfied with the medical treatment I received from the doctor. (26)
5. I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition. (32)
6. I am satisfied with the physician's courtesy towards me. (35)
7. I search the Internet for more information about my medical problems. (40)

Appendix E: Frequency distribution for each statement (Pre-test No.1)

	1		2		3		4		5	
	#	%	#	%	#	%	#	%	#	%
1. My doctor told me all I wanted to know about my medical condition and its treatment	1	2			2	4	3	7	39	87
2. The doctor told me his/her plans for my treatment	1	2			4	9	5	11	35	78
3. I felt able to tell this doctor about personal matters	12	27	2	4	5	11	5	11	21	47
4. I did not understand everything the doctor told me, because he does not speak my language	14	67	2	10	1	5	1	5	3	14
5. The doctor wanted me to share with him/her the decision about my treatment	13	29	2	4	3	7	8	18	19	42
6. I prefer to be examined by a female doctor	33	89			1	3			3	8
7. The doctor interrupted me frequently during our conversation	1	2	1	2			2	4	41	91
8. It important to me that the doctor tell me everything about my medical condition and treatment	1	2					6	13	38	84
9. I would prefer to be examined by a doctor who speaks my language	10	45	1	5	3	14			8	36
10. The doctor seemed interested in me as a person	2	4	2	4	2	4	6	13	33	73
11. I want my doctor to decide what the best treatment is for my medical condition	3	7			3	7	8	18	31	69
12. I had enough time to ask the doctor all I wanted to know	1	2	1	2	1	2	6	13	36	80
13. The doctor answered all my questions			1	2	3	7	4	9	37	82
14. The doctor encouraged me to talk about my concerns	9	20	8	18	3	7	6	13	19	42
15. I felt that the doctor did not understand everything I told him because he does not speak my language	18	90	1	5	1	5				
16. Some things during my consultation with the doctor could have been better	2	4	3	7	4	9	2	4	34	76
17. I want to get more information about my medical condition and treatment from my relatives	36	80	2	4			4	9	3	7
18. I want the doctor to let me participate in the decision of choosing the treatment for my medical condition	9	20	2	4			3	7	31	69
19. The doctor spoke clearly and I understood what he told me	40	89	1	2	3	7	1	2		
20. The doctor seemed to be in a hurry	3	7	2	4	1	2	2	4	37	82
21. The doctor encouraged me to ask questions	11	24	4	9	2	4	11	24	17	38
22. I want to consult my family regarding the treatment for my medical condition	22	49	3	7	2	4	4	9	14	31
23. The doctor explained things in words I could not understand	37	86			2	5	1	2	3	7

	1		2		3		4		5	
	#	%	#	%	#	%	#	%	#	%
24. I would have liked to spend more time with the doctor	5	11	2	5	3	7	2	5	32	73
25. The doctor did most of the talking during the visit	10	22	10	22	9	20	6	13	10	22
26. I want to be more involved in the decision regarding my treatment than the doctor let me.	27	60	6	13	3	7	4	9	5	11
27. Sometimes the doctor talked down to me	1	2	1	2	1	2			42	93
28. I feel more comfortable talking about emotional problems with a female doctor	34	76	2	4	1	2	5	11	3	7
29. The doctor gave me a chance to say everything that was on my mind	2	4	1	2	2	4	4	9	36	80
30. I prefer to be examined by a male doctor	9	100								
31. The doctor and I laughed and joked together during the visit.	19	42	8	18	7	16	6	13	5	11
32. The doctor clearly explained my medical condition			1	2	1	2	3	7	40	89
33. I want to consult my Rabbi / Sheikh / Priest about the treatment for my medical condition	42	95	1	2	1	2				
34. I am satisfied with the health care I received from the doctor	1	2	1	2	1	2	2	4	40	89
35. The time I was able to spend with the doctor was too short	3	7	4	9	3	7	1	2	34	76
36. The doctor discussed the options for my treatment with me	5	11	3	7	2	4	14	31	21	47
37. I want to get more information about my medical condition by searching the Internet	7	16	4	9			2	4	32	71
38. I felt the need for someone to translate during the visit	19	70			1	4			7	26
39. The doctor treated me with dignity and respect							3	7	42	93
40. The doctor listened carefully to everything I said					2	4	2	4	41	91
41. I felt the doctor really understood me			1	2	1	2	4	9	39	87
42. I want to consult my friends about the treatment for my medical condition	39	87	2	4	1	2	2	4	1	2
43. I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition			3	7	2	4	4	9	36	80
44. After talking to the doctor, I understand everything about my medical condition	1	2	1	2	3	7	9	20	31	69
45. I would have liked someone else other than my family member to translate during the visit.	16	84			1	5			2	11
46. The doctor asked me about my family and my personal life	28	62	2	4	4	9	2	4	9	20
47. I feel more comfortable talking about my medical problems with a male doctor	36	80			1	2	1	2	7	16
48. I am satisfied with my visit to the doctor			2	4	1	2			42	93

Appendix F: Pre-test No.1- rephrased statements

a. Statements No.6 and No.30, "I prefer to be examined by a female doctor" and "I prefer to be examined by a male doctor", were combined and rephrased:

I would prefer to be examined by

1 a male physician 2 a female physician 3 no preference

b. Statement No.7: "The doctor interrupted me frequently during our conversation" was rephrased:

The doctor interrupted me sometimes during our conversation.

c. Statement No.18: "I want the doctor to let me participate in the decision of choosing the treatment for my medical condition" was rephrased:

I want to decide together with the doctor about the treatment for my medical problem.

d. Statement No.19: "The doctor spoke clearly and I understood what he told me" was rephrased:

The doctor used clear language and I understood what he told me.

e. Statement No.28: "I feel more comfortable talking about emotional problems with a female doctor" was rephrased:

I feel more comfortable talking about my emotional problems with

1 a male physician 2 a female physician 3 no preference

f. Statement No.33: "I want to consult my Rabbi / Sheikh / Priest about the treatment of my medical problem" was rephrased:

It's a good idea to consult a religious clergyman (Rabbi / Sheikh / Priest) about medical problems.

g. Statement No.37: "I want to get more information about my medical condition by searching the Internet" was rephrased:

I have the habit of searching the Internet for more information about my medical problems

1 yes 2 no 3 other

h. Statement No.39: "The doctor treated me with dignity and respect" was rephrased:

This doctor treats his patients with dignity and respect.

i. Statement No.42: "I want to consult my friends about the treatment for my medical condition" was rephrased:

It's also a good idea to consult with friends about medical problems.

j. Statement No.47: "I feel more comfortable talking about my medical problems with a male doctor" was rephrased:

I feel more comfortable talking about my medical problems with

1 a male physician 2 a female physician 3 no preference

k. Statement No.48: "I am satisfied with my visit to the doctor" was rephrased:

I am satisfied with the doctor's courtesy towards me.

Appendix G: Means and SD's of patient needs, attitudes and satisfaction according to physician and patient cultures

Physician culture		Jewish-Israeli				Arab-Israeli				Russian-Israeli				Total			
Patient culture		Israeli	Arab	FSU	Total	Israeli	Arab	FSU	Total	Israeli	Arab	FSU	Total	Israeli	Arab	FSU	Total
Information-seeking and giving	M	4.24	4.07	3.66	3.99	4.15	4.12	3.85	4.04	4.03	3.84	3.76	3.87	4.14	4.01	3.76	3.97
	SD	.51	.66	.87	.74	.57	.58	.72	.64	.71	.87	.71	.77	.61	.72	.77	.72
Participatory decision-making	M	2.60	2.16	2.48	2.41	2.53	1.97	2.16	2.22	3.00	2.25	1.92	2.39	2.71	2.13	2.19	2.34
	SD	1.39	1.42	1.59	1.48	1.44	1.42	1.39	1.43	1.43	1.40	1.26	1.43	1.43	1.42	1.44	1.45
The doctor wanted me to share with him/her the decision about my treatment (4)	M	3.51	3.21	2.62	3.11	3.39	3.05	2.11	2.85	3.01	3.01	3.07	3.03	3.30	3.09	2.60	3.00
	SD	1.28	1.41	1.58	1.47	1.33	1.47	1.33	1.48	1.43	1.52	1.56	1.50	1.36	1.46	1.54	1.48
Consulting with others	M	1.91	1.61	1.77	1.76	1.96	1.77	1.85	1.86	1.95	1.79	1.62	1.79	1.94	1.72	1.75	1.80
	SD	.83	.60	.76	.75	.84	.83	.75	.81	.80	.87	.69	.80	.82	.78	.74	.79
Physician's interpersonal communication	M	3.36	3.09	2.54	3.00	3.25	3.28	2.28	2.93	3.15	2.75	3.03	2.98	3.25	3.04	2.62	2.97
	SD	.75	.74	.90	.87	.79	.82	.72	.90	.98	.84	.86	.91	.85	.83	.89	.89
Some things about my consultation could have been better (12)	M	1.77	2.21	2.78	2.25	1.88	2.13	2.53	2.18	2.45	2.50	2.40	2.45	2.03	2.28	2.57	2.29
	SD	1.03	1.15	1.31	1.24	1.02	1.15	1.22	1.16	1.19	1.16	1.13	1.15	1.12	1.16	1.23	1.19
I am satisfied with the medical treatment I received from the doctor (26)	M	4.63	4.30	4.05	4.32	4.52	4.31	4.18	4.34	4.33	4.14	4.35	4.27	4.49	4.25	4.19	4.31
	SD	.57	.92	1.20	.96	.70	.92	1.08	.92	.94	1.09	.92	.99	.76	.98	1.08	.96
I am satisfied with the doctor's courtesy toward me (35)	M	4.54	3.94	3.59	4.02	4.33	4.12	3.75	4.06	3.81	3.58	3.98	3.79	4.22	3.88	3.77	3.96
	SD	.74	.92	1.11	1.01	.84	.85	.99	.93	.96	1.03	.89	.97	.90	.96	1.01	.98
Verbal communication	M	1.23	1.69	2.28	1.74	1.36	1.28	2.23	1.62	1.36	1.85	1.44	1.55	1.32	1.61	1.98	1.64
	SD	.42	.85	1.10	.94	.60	.60	.91	.84	.67	.92	.76	.82	.57	.84	1.01	.87
I prefer to be examined by a doctor who speaks my language (6)	M	3.43	2.42	3.81	3.22	2.91	2.94	3.87	3.24	3.92	2.33	4.77	3.67	3.42	2.56	4.15	3.38
	SD	1.84	1.76	1.55	1.81	1.76	1.86	1.63	1.81	1.63	1.68	.70	1.74	1.79	1.78	1.42	1.80
Time	M	1.83	1.95	2.34	2.04	1.73	1.88	2.07	1.89	2.09	2.30	2.17	2.18	1.88	2.04	2.19	2.04
	SD	1.04	1.08	1.29	1.16	.95	1.05	1.15	1.06	1.16	1.21	1.19	1.18	1.06	1.13	1.21	1.14
I need more time to get acquainted with the doctor, before I can tell him/her... (32)	M	1.74	2.59	2.15	2.16	1.76	2.83	2.02	2.20	1.91	2.64	1.91	2.15	1.80	2.68	2.02	2.17
	SD	1.20	1.18	1.46	1.33	1.12	1.34	1.39	1.37	1.19	1.25	1.25	1.27	1.17	1.26	1.37	1.32

** $p < .01$; ***$p < .001$

Appendix H: Two-way MANOVA examining differences between groups of patients according to patient and physician cultures: F values and P values

	Source of variance (F values)					
	Physician culture		Patient culture		Interaction: Physician x patient culture	
	F	p	F	p	F	p
Information-seeking and giving	4.67**	.007	21.70***	.000	3.29**	.04
Participatory decision-making	.55	.157	8.80***	.000	5.83***	.007
The doctor wanted me to share with him/her the decision about my treatment (4)		.063		.000		.000
Consulting with others	1.31	.272	7.47***	.001	1.46	.214
Physician's interpersonal communication	.14	.632	39.10***	.000	19.41***	.000
Some things about my consultation could have been better (12)	4.81**	.009	17.92***	.000	6.15***	.000
I am satisfied with the medical treatment I received from the doctor (26)	.42	.658	9.24***	.000	3.27**	.011
I am satisfied with the doctor's courtesy toward me (35)	8.19***	.000	21.21***	.000	11.97***	.000
Verbal communication	4.81**	.013	59.81***	.000	25.67***	.000
I prefer to be examined by a doctor who speaks my language (6)	8.11***	.000	78.15***	.000	9.36***	.000
Time	4.25**	.004	8.52***	.002	1.82	.144
I need more time to get acquainted with the doctor, before I can tell him/her about my medical condition (32)		.851		.000		.299