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Limits of 'patient-centredness': valuing contextually specific communication patterns

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CONTEXT Globally, doctor–patient communication is becoming synonymous with high-quality health care in the 21st century. However, what is meant by 'good communication' and whether there is consensus internationally remain unclear.

OBJECTIVES Here, we characterise understandings of 'good communication' in future doctors from medical schools in three contextually contrasting continents. Given locally specific socio-cultural influences, we hypothesised that there would be a lack of global consensus on what constitutes 'good communication'.

METHODS A standardised two-phase methodology was applied in turn to each of three medical schools in the UK, Egypt and India (n = 107 subjects), respectively, in which students were asked: 'What is good communication?' Phase I involved exploratory focus groups to define preliminary themes (mean number of participants per site: 17). Phase II involved thematic confirmation and expansion in one-to-one semi-structured interviews (mean number of participants per site: 18; mean hours of dialogue captured per site: 55). Findings were triangulated and analysed using grounded theory.

RESULTS The overarching theme that emerged from medical students was that 'good communication' requires adherence to certain 'rules of communication'. A shared rule that doctors must communicate effectively despite perceived disempowerment emerged across all sites. However, contradictory culturally specific rules about communication were identified in relation to three major domains: family; gender, and emotional expression. Egyptian students perceived emotional aspects of Western doctors' communication strikingly negatively, viewing these doctors as problematically cold and unresponsive.

CONCLUSIONS Contradictory perceptions of 'good communication' in future doctors are found cross-continentally and may contribute to prevalent cultural misunderstandings in medicine. The lack of global consensus on what defines good communication challenges prescriptively taught Western 'patient-centredness' and questions assumptions about international transferability. Health care professionals must be educated openly about flexible, context-specific communication patterns so that they can avoid cultural incompetence and tailor behaviours in ways that optimise therapeutic outcomes wherever they work around the globe.

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INTRODUCTION

Globally, definitions of 'good communication' with patients and the issue of whether there is global consensus are surprisingly unclear. This is despite ubiquitous recognition[1–4] that doctor–patient interaction is critical to health care outcomes.

The vast majority of research in relation to good communication has focused on single Western institutions and is often biased by sampling restricted to well-resourced settings. However, these data may not be globally representative as nearly half of the world's patients live in rural locations,[5] and findings in low-resource settings may be incomparable with those in urban research environments. The potentially marked differences in local variables (environmental, societal, religious and cultural) render Western-derived views on good communication of questionable generalisability when extrapolated globally.[6]

Globalisation is a multidimensional construct[7] that includes dynamic international processes such as increasing interconnectedness and availability of transportation between populations. Current levels of globalisation are unprecedented, and understanding how society and culture influence communication has become increasingly relevant and important.

The cross-border migration of both patients and health professionals has resulted in increasing recognition of ever-growing diversity.[8] Moreover, cultural misunderstandings have been linked with poorer communication,[9] patient dissatisfaction, poorer health outcomes and racial disparities,[10] as well as with educational underachievement in examinations in members of ethnic minority groups.[11] Historically, there have been many different approaches to communication, such as those of paternalism[12] and consumerism,[13] each with its own merits. With constantly evolving societal changes, research into the effects of globalisation on health has become increasingly important in terms of improving and standardising the provision of care.[14,15]

One of multiple approaches to communication[16] is that of 'patient-centredness'. This relatively recent concept, constructed over the last few decades and associated with North America[17] and northern Europe,[2,18] currently predominates in thinking in high-resource institutions. Patient-centredness encompasses many broad factors associated with doctor–patient relations[2] and interestingly assumes that interaction should be directed primarily to 'the patient as a person', emphasising individual uniqueness,[19] rather than focusing on the patient's partner or family unit, or collectivist priorities. It also advocates responding to patient emotions, although it does not explicitly provide guidance on tailoring communication in a gender-specific, emotional or intimate way.

Although it appears to confer promising benefits specifically in Western contexts, patient-centredness continues to spread worldwide and is largely untested in low- and medium-resource settings. Potential concerns over its prescriptive 'one-size-fits-all' approach have arisen.[20] It may be inflexible in relation to disparate cultures,[21–23] where understanding of the communication environment is absent or qualitatively different.[6]

The aim of this study was to characterise understandings of 'good communication' across contrasting medical schools in different socio-cultural contexts. Schools in three continents in which student migration is commonplace were sampled for enhanced global representativeness and to maximise the relevance of findings for improving health care systems globally. Given that the influences of trends, including those of procedural evidence-based medicine, taught professional boundaries and the rise of 'scientific bureaucratic medicine', differ between the UK and India and Egypt,[24] we hypothesised that we would find: (i) a lack of global consensus on what constitutes good communication, and (ii) a UK-specific procedural focus on communication potentially at the expense of emotional engagement.

METHODS

The socio-cultural and contextual characteristics of the three medical schools can be found in Table 1. Specifically, Mansoura Medical School (Mansoura University, Mansoura, Egypt) was selected because it has links with Manchester Medical School (University of Manchester, Manchester, UK) through a shared curriculum. Kerala Medical College (Mangode, Kerala, India) had been visited by VW, but had no formal links with Manchester Medical School.

Study design and sampling

A mixed-method design using first focus groups and then interviews was applied sequentially to each school in turn (in the UK, India and Egypt), allowing for the triangulation of data sources. The medical school in Manchester was particularly notable

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Table 1 Medical school characteristics

	Manchester	Kerala	Mansoura
Location (sample size)	Northern UK, Western Europe Urban (*n* = 37)	South India, South Asia Rural (*n* = 37)	Egypt, North Africa Urban (*n* = 33)
Male	18 (49%)	17 (46%)	22 (67%)
Female	19 (51%)	20 (54%)	11 (33%)
Predominant ethnicity, language, religion	White British 23 (62%), English, Christianity	Indian 36 (97%), Malayam, Hinduism	Egyptian 30 (91%), Arabic, Islam
Age, years, mean (range)	22.6 (21–26)	22.6 (21–26)	21.7 (20–25)
Year of training, mean (range)	4.1 (3–5)	4.4 (4–5)	5.1 (4–6)
Setting	Government-funded teaching hospitals	Charitable Muslim hospital	Mixed public/private funding
Students	Mixed undergraduate and postgraduate	Predominantly undergraduate	Predominantly undergraduate
Interview duration, min, mean	FG: 50.9; individual: 55.5 (two FGs, 19 individual)	FG: 51.7; individual: 59.0 (two FGs, 19 individual)	FG: 45.3; individual: 57.5 (two FGs, 18 individual)
Curriculum	Problem-based learning	Traditional lecture-based	Traditional lecture-based
Communication skills training	Explicit	Implicit	Implicit

FG = focus group.

for its ethnic diversity. Data collection was comprehensively completed in each school before the next was investigated, using the constant comparative method throughout. The sampling frame included students in the clinical years of training (Years 3–6) who had personal experience with doctor–patient interactions. Participants were purposively sampled for gender and ethnicity to reflect local year group demographics as far as possible. Students capable of conversational English were invited to enrol with the aim of allowing them to express their views in their own words. In the UK, e-mails were sent out to all students in the clinical years. In Egypt and India, where this was not possible, students were recruited through announcements at lectures. As with a previous study's methodology,[11] the friends and acquaintances of students were not actively excluded to allow for the 'collective remembering' of events and to help put participants at ease. Two focus groups (Phase I) were followed by structured interviews (Phase II) at each of the medical schools.

Phase I: focus groups

TBM (White British male, Year 4 student) conducted two exploratory focus groups to identify broad themes of communication, and to explore and allow students to discuss sensitive issues together with their peers.[11] A semi-structured question framework was used. Students were asked to elaborate as fully as possible in their responses to the question: 'What is good communication?' They were then prompted to expand their answers with the follow-up questions: 'What are your expectations in the doctor–patient relationship?' and 'Are these affected by culture and society, and if so, how?'

Phase II: interviews

Students who had not already participated in a focus group were invited to participate in in-depth, one-to-one, semi-structured interviews with TBM to confirm and enrich themes until thematic saturation was achieved. Students were allowed to attend individual interviews accompanied by a friend if they were prohibitively apprehensive about attending alone for religious reasons. Throughout both focus groups and interviews, open questions were used to facilitate discussion. Field notes were recorded. Focus groups and interviews were tape-recorded and transcribed verbatim.

Data analysis and validation

Data were initially coded by RW and NC-M, who were medical students at the time, using NVivo

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Table 2 Major themes and sub-themes: rules of good communication

Theme/sub-theme	Description	UK	India	Egypt
Shared rules				
Dealing with disempowerment	Increasingly disempowered doctors relative to increasingly educated patients	↑	↑	↑
Contradictory rules				
Patient-centrism (versus family-centrism)	Care for the patient rather than the family represented the priority	↑	↓	↓
Gender-blindness (versus gender-tailoring)	Gender is largely irrelevant rather than critical in the doctor–patient interaction	↓	↑	↑↑
Emotional detachment (versus emotional intimacy)	Communication should remain detached and should be 'professional' and non-tactile rather than emotive and familiar	↑	↓	↓↓

Arrows indicate the relative strength and consistency of reported agreement with and adherence to the respective rules.

Version 8.0 (QSR International Pty Ltd, Melbourne, Vic, Australia). NC-M coded the UK data; RW coded the data from Egypt, and both NC-M and RW coded the data from India. Different coding frames were used across each of the three sites according to the data that emerged at that site. The three coding frames were amalgamated across all sites by the researchers' achievement of consensus on which themes were most salient. Thematic analysis was performed through discussion and collaboration among all authors, and repeated after subsequent reviewing of the data. Hypotheses and interpretations were constantly compared with verbatim quotes using the constant comparative method. Internal validity was achieved by examining consistencies across themes, data (focus groups and interviews shared the same coding frame) and existing literature. Opposing views were taken into account. The plausibility of themes was subsequently verified by investigators (VW and HB are experienced tutors) and by medical students from different medical schools including PM, NC-M and RW. PM advised on inherent linguistic issues throughout the study and refined themes. TBS contributed to the design of the methodology, and to the discussion and contextualisation of emerging themes in relation to the sociological literature.

Ethical approval: Ethical approval was obtained in advance from Manchester University's Ethics Committee. The study was ethically approved locally by the medical schools in Mansoura and Kerala. Students gave informed written consent to their participation in accordance with the Declaration of Helsinki.

RESULTS

Themes

Two overarching major themes emerged in 'rules of communication' that were either shared or contradictory between sites. Sub-themes emerged within these two major themes. One rule was shared across all sites, whereas three rigid rules were expressed in site-dependent but contradictory ways (Table 2). The following code structure is used to denote respondent characteristics: (respondent number, medical school site, age, ethnicity [A = Asian; E = Egyptian; I = Indian; WB = White British], gender [M = male; F = female]).

Dealing with disempowerment

Across all sites, students described having to deal with the perceived increasing disempowerment of doctors whilst communicating with patients:

> The days of paternalistic care where you tell the patient what to do and they do it are gone. (R24, UK, 22, WB, M)

Patients were considered to have become more powerful and this was sometimes perceived negatively:

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> In the olden days doctors were considered equal to God. Nowadays the relationship has worsened... They are gaining more and more knowledge and the doctor is having to explain himself. (R16, India, 21, I, F)

There were also mixed feelings; students identified the positive effects of patient empowerment in terms of health awareness and compliance and the role of the Internet in enabling patients globally:

> It's like a shift in expectations... They look up a condition they might have on the Internet now, and see that there's a possible treatment emerging in America sort of thing... (R14, UK, 21, WB, M)

Across all sites, this appeared to create a sense that doctors must deal with 'disempowerment' as knowledge was no longer imparted only by doctors themselves; the rules of communication had changed:

> ...patients come in... wanting treatment... and that's what sometimes doctors find very frustrating. (R13, UK, 21, WB, M)

Students understood that this was an important issue in the modern doctor–patient relationship, yet expressed a sense of unease about how patients were attaining this new information:

> [It's] difficult... they think that doctors will have to convince them about surgery, about treatment options and many of them are biased about side-effects of medicines. (R16, India, 21, I, F)

In Egypt and India, where patients 'shop' for doctors, students expressed strong concerns that patients would not trust them and would go elsewhere if they did not provide immediate emotional satisfaction or hold all the knowledge:

> They start distrusting him [the doctor]. Again, it goes back to the culture and the understanding of medicine, we tend to believe in these parts of the world that the doctor has to know everything about every disease. (R1, Egypt, 23, E, M)

The rise in levels of legal proceedings brought against doctors by their patients had begun to sensitise students across all sites and was deemed to impact negatively on engagement:

> The culture of this okay you have to know if you made the mistake you will be sued, and maybe you will go to jail. (R23, Egypt, 23, E, M)

There was a sense that this increase in litigation would eventually force doctors into safe and defensive practice: 10

> Litigation, maybe it's changed the doctor's kind of point of view in the doctor–patient relationship they'll be more restrained or more careful about things. (R6, UK, 21, WB, F)

Students in Egypt and India associated the higher levels of patient knowledge with high socio-economic status, and perceived such knowledge as creating high expectations of the doctor and even a sense of competition: 11

> Doctors get irritated easily because of these educated patients who are coming, they're having some knowledge of the disease... (R12, India, 22, I, F)

> He is like "you think you know more than me"...it is like a competition more than a doctor–patient relationship. (R9, Egypt, 20, E, F)

Consequently, patients were able to wield more power in the relationship. Doctors reacted by classifying patients by class and preferentially responding to higher- rather than lower-status patients:

> When a patient is from high levels of the community, the doctor will pay more attention to him, conversely when he comes from a village... he won't pay any [attention] to him – just gives him medicine... and lets him go. (R25, Egypt, 23, E, M)

By contrast, only one student in the UK overtly described situations in which social status had bearing on the doctor's behaviour. Whilst dealing with disempowerment, students across all sites shared views that good communication was vital for patients and involved trust and compassion.

Patient-centredness versus family-centredness

Students held contradictory and inflexible opinions of where 'power' and priority lie when engaging with patients and families. Not surprisingly, Manchester students unanimously adhered to a rule of patient supremacy:

> Your priority would always be towards the patient... the family is less important. (R10, UK, 23, WB, M)

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Conversely, students in India and Egypt consistently stated direct engagement must primarily be with the family, not the patient:

> . . .rather than the family, it is more important to involve the relatives or bystander[s]. . . (R34, India, 23, I, F)

> There is no question about keeping the relatives informed. (R8, Egypt, 23, E, M)

However, it emerged in all contexts that students appeared to describe rules that risk being perceived as a means of offloading responsibility from the doctor:

> First you have to communicate with his family so you can send your message to them and they will deal with him. . . (R33, Egypt, 23, E, F)

A sense of delegation to family also emerged from the Manchester discussions, although this was patient-dictated:

> Well sometimes patients delegate responsibility to their partners or children. . . A lot of patients do that. But again it's up to the patient. (R5, UK, 23, A, M)

In a sense, working through the family appeared to give the student a sense of security in that the family was assumed to have the know-how to deal with a problem such as cancer:

> . . .for the sake of the patient, definitely the doctor can hide it [diagnosis or health status] from him and disclose it to the family members and they will take care of it. . . (R21, UK, 23, I, M)

In both Kerala and Mansoura, this frequently reflected a perceived relative incompetence of the patient:

> The patient is unaware of how to take treatment. . . So I think the involvement of relatives is more important than the patient. (R1, India, 22, I, M)

By contrast, in Manchester the presence of a family or a spouse risked being viewed as a threat as it might interfere with management:

> If their family's overbearing and trying to get them to make decisions that their family wants, then that's not supporting the patient. (R29, UK, 22, WB, F)

It was clear that families were a peripheral afterthought for British students, but a cornerstone of communication, satisfaction and compliance for students in India and Egypt.

Gender blindness versus gender tailoring

The rules of communication relating to gender differed among the sites. In Egypt at a high level and in India at a lower level, engaging with patients of the opposite gender was discouraged. Mixed-gender interaction was viewed as restrictive ('Gender is a restriction, an obstacle' [R20, India, 22, I, F]) and invasive ('It is something that is my privacy you know, breaking inside my privacy' [R15, Egypt, 22, E, M]). A clear sense that single-sex interactions made communication much easier was apparent:

> If it is a boy, I am a male and he is a male. . . we have easier communication, if I say it to girls. . . it is not nice. (R15, Egypt, 22, E, M)

Cultural sensitivities within the Muslim tradition around customs such as handshakes were apparent in the Egyptian transcripts. In Manchester, gender was less of a barrier to a successful relationship, but at all sites performing intimate examinations was frequently associated with difficult feelings and outcomes:

> That's a fear in me, that's an insecurity in me. That will reflect upon what I'm doing. . . scared to be like in a closed room. . . (R17, India, 22, I, F)

> . . . if the lady is insulted by any means then she may go to the courts. (R16, India, 21, I, F)

Manchester students reported no perceivable effect of gender on everyday practice or communication:

> Gender in this country – that shouldn't really be relevant. . . Not for doctors or professionals. (R10, UK, 23, WB, M)

Gender differences emerged as having a dramatic impact on the quality of the doctor–patient relationship in Egypt and India. Well-formed, fixed stereotypes emerged in how students described their approaches to a patient. In Egypt, and to a lesser extent India, there was a strong sense that female patients should be treated differently from men:

> The male may become rigid. . . he may not appear as affected as the female. The female

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> differs... females are more emotional. We deal with females in a more kindly manner. (R29, Egypt, 20, E, M)

Women were frequently referred to as the weaker sex:

> ...they don't really handle things well, they measure things with their emotions rather than their mind. (R35, India, 23, I, M)

Concerns also emerged that inappropriate feelings such as those of sexual attraction might develop or be misinterpreted between the patient and doctor:

> ...the patient can get emotionally attached to the doctor who just, the doctor is just trying to be nice... (R9, Egypt, 20, E, F)

This was accompanied by similar concerns in Egypt about conversations with members of the opposite gender among students themselves:

> This is so embarrassing; she told me "I saw you with a guy": they're not very open-minded about the male–female conversations. (R21, Egypt, 21, E, F)

These sensitivities within their own student culture appeared to intertwine with students' approaches to patients.

Gender was also perceived as influencing the patient's respect for and response to the doctor. A Manchester student observed the following from attending a consultation:

> He was a 60-year-old man... and he had no respect, no respect for women at all... And so wouldn't listen to anything that a woman doctor told him... (R11, UK, 23, WB, F)

There were very clear and consistent stereotypes and a sense that male doctors were on a different trajectory to women:

> ...there are good students female and male. Usually, males are better than females. Males are tougher... females are known to be more emotional... (R32, Egypt, 24, E, M)

> ... in our society it's difficult because there is the concept that the leader, leaders are for men... (R34, India, 23, I, F)

In Egypt there was a strong sense that a woman's role was within the family. In Kerala, there was a sense that this may be changing:

> ...now you find men sitting at home, females earning... nowadays everybody is like, if you have money coming in it doesn't really matter, whichever way. (R33, India, 23, I, M)

These stereotypes did not emerge within the Manchester students, although there was a slight undertone of reservation:

> You want to just feel like you're in safe hands, not if you're in the right hands sex-wise. I'm not sure how it is in the workplace itself but... (R19, UK, 21, WB, M)

Emotional detachment versus emotional intimacy

Rules determining how much doctors should express emotion and familiarity differed widely among the three sites. Both Egyptian and Indian students stressed that to overcome patients' doubt and mistrust, doctors must display emotion and familiarity rather than professionalism:

> The Eastern community as it is dependent on the emotional side than the professional side. (R19, Egypt, 23, E, M)

Emotional display was prominent in Egypt and was related to national identity:

> We Egyptians are very emotional people. (R9, Egypt, 20, E, F)

Students perceived that patients must be made to feel close and familiar to encourage them to trust the doctor:

> Doctors are at the top of the family with the patients... really close. (R22, India, 23, I, M)

This extends to a point at which doctors commonly address patients as family members:

> So calling people "Mummy" or "Auntie" is very common – something to be loved by patients. (R10, Egypt, 20, E, F)

Physical touch was also viewed as important non-verbal communication:

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> Behave to them as if a son is behaving to a mum… holding the hand of the patient… a healing touch. (R27, India, 23, I, F)

By contrast, UK students found physical contact with patients inappropriate and risky:

> Empathise with words – [it's] a lot easier… without crossing any boundaries. (R19, UK, 21, WB, M)

Further, Egyptian students perceived Western doctors as problematic in their responses to patients' emotions and their ability to comfort them. Egyptian students described Western doctors as starkly negative in this regard. They were characterised as emotionally detached by some students:

> Western doctors are "cold mountains"; they don't really care for you. (R16, Egypt, 22, E, M)

They elaborated that Western doctors were seen as showing mere professional responsibility, rather than heartfelt genuine personal investment although they are perceived to be procedurally or 'mechanically' proficient:

> …they have no mercy… they just make you healthy. (R16, Egypt, 22, E, M)

Other Egyptian students substantiated this characterisation when questioned about its representativeness. Students characterised Western communication styles as involving unrestrained truth-telling to patients, which they perceived as merciless and lacking in compassion:

> What about this "cold mountain" idea? (TBM, interviewer)

> Some have no mercy… you just want to tell the patients the facts… (R9, Egypt, 22, E, F)

Manchester students recognised the potential risk of being perceived as 'cold' in their communication, but failed to identify this as a characteristic occurrence in their culture:

> You don't want to come across as someone who's quite cold and harsh but is, you know, an excellent clinician. (R28, UK, 22, WB, M)

DISCUSSION

This multicentre study is the first, to our knowledge, to characterise global understandings of communication using data from three medical schools in both high- and low-resource settings. In line with our hypothesis, key discrepancies in understanding across schools were found, indicating a lack of global consensus on what 'good communication' entails, along with striking evidence of differential emotional engagement according to the local socio-cultural context in which the medical school was embedded. Although doctors at all sites felt disempowered as communicators, contradictory 'rules of communication' were found across the sites. This indicates a lack of global consensus on 'good communication'. Culturally oppositional understandings of the roles of family, gender and emotional expression were identified. Hence, these factors may be implicated in cross-cultural communication difficulties that result from discrepant beliefs about communication and may usefully inform medical educators developing cultural competence curricula. In addition, our findings call for a greater awareness of striking differences in communication and value systems, and extend research that has previously been limited to urban Western academic settings. Such findings are of increasing importance in the context of ongoing globalisation and mixing of cultures through processes such as enculturation and acculturation, whereby individuals acquire characteristics of their own and other cultures.[25]

Unlike several studies on clinical communication, this study is unusual in that it focuses not on actual doctors, but on student doctors and their socio-cultural challenges in the communication process across culturally diverse settings. Data provide insight into student perceptions during the early stages of their careers, in which understandings may not yet be fully formed. The results reveal attitudes that show how future doctors perceive they will generally approach patients, rather than their clinical or medically focused problem. Hence, the data reveal the context of the doctor–patient relationship rather than clinically oriented technical specifics on disease or illness. The findings highlight concerns relating to external constraints and challenges that impact on communication more broadly. In providing this novel perspective, which is not restricted to the context of a single medical specialty or condition, this paper raises the question of whether new observations can yield new lessons.

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Cross-cultural differences found in the current qualitative study may help explain data from quantitative studies that have identified inconsistent interpretations and enactments of communication and patient-centredness according to nationality[26] and ethnicity and culture.[27] Specifically, self-report questionnaires have identified differences relating to family,[12,28] truth telling[12] and gender[17] across contexts. Consistently with our findings relating to socio-economic status, class has been found to affect communication.[29] Previous work has also found evidence that other differing variables across sites, such as religiosity,[30,31] work experience,[32] exposure to medical specialties[29] and stakeholder background,[18] may affect communication. Unlike previous quantitative studies, the current study provides contextualised explanations that may help to explain observed quantitative differences in communication behaviours according to different factors by detailing and describing discrepant cultural interpretations of good communication.

Our findings are consistent with those of previous qualitative studies that have identified differences in interpreting dimensions of patient-centredness, including autonomy, within Western contexts such as Italy and the USA.[1] Universal findings of perceived doctors' disempowerment are consistent with the 'crisis in [the doctor–patient] relationship'[33] previously described and may involve social trends such as mass media, health privatisation, malpractice litigation and managed care. Similarly, our findings on gender in India support the results of a previous study reporting on the salience of traditional gender roles in Indian health care.[13]

This study has limitations. Its findings reflect the views of subjects willing to participate in research with a White British male researcher (TBM), which may mean that non-Western or extreme views were under-expressed. Additionally, as TBM was trained in a patient-centred approach, this may have affected his questioning and interpretation. Secondly, similarly to previous work,[34] students were reluctant to discuss issues of culture and race, suggesting the need for greater openness and the provision of non-judgemental support in discussing issues.

The lack of cross-cultural consensus on good communication may have implications.

This study provides empirical evidence for the further questioning of the international transferability of patient-centred paradigms beyond procedurally oriented Western individualist societies into experience, as well as into emotionally oriented collectivist contexts. This may particularly relate to the individualistic versus collectivist dimension of cultures described by Hofstede.[35] It highlights that patient-centredness may be negatively evaluated outwith Western settings, which may relate to its overly individualist features, consequent neglect (underutilisation) of families and wider communities, genericness of communication untailored according to gender, and, concerningly, inadequate and 'cold' emotional engagement. Differences in gender stereotypes may be partly explained by the cultural dimension of the masculinity/femininity dichotomy.[35]

The study also raises several questions. One of these refers to how we can best interpret and acknowledge the complex heterogeneity in views across the various sites, and what the effects on students' views of the many contextual variables, such as class, gender and previous clinical exposure, may be. Such complexities extend beyond the scope of this study but deserve consideration. Further research is warranted to quantify the extent and prevalence of views described in this study and the interaction of these variables.

Western-derived conceptions of patient-centredness may be too narrow and 'biomedicalised' for global application. This challenges the appropriateness of attempts to recommend universal patient-centredness through standardised care and National Institute for Health and Care Excellence (NICE) guidelines. One obvious way forward involves the application of learning from other cultures in order to redefine person-centred medicine more broadly. Alternatively, to non-Western students, traditional person-centred definitions may require a fundamentally more comprehensive conceptualisation potentially with a shift towards what might be termed 'family-' or 'community-oriented' care. This would include more explicit and salient recognition of influential factors such as gender, family and social impact on communication. As health providers increasingly migrate, the encountering of discrepant expectations of good communication will be inevitable. Guidance must therefore be developed so that future doctors can either retain existing communication styles or be empowered to challenge locally entrenched approaches and acquire flexible communication strategies depending on what best serves not only the patient in front of them, but

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also local communities and health outcomes globally.

CONCLUSIONS

Understanding socio-cultural factors has been prioritised internationally in order to inform and tailor curricular development in areas of 'cultural competence',[36,37] communication skills[6] and professionalism.[38] This is equally important in local settings with high levels of cultural diversity, such as some in the UK, as it is for those travelling abroad.[9] Patterns of cross-cultural communication misunderstandings must be identified and avoided if health care workers are to be trained to respond sensitively and appropriately to patients from varied backgrounds and to mobilise effectively across health systems in the 21st century. There appears to be a need for reflection on and reconsideration of what it means to provide 'person-centred' or 'holistic' care in light of these results. Western medicine may have evolved in ways that fail to keep abreast of escalating trends in not only clinical complexity and multi-morbidity, but also cultural complexity.

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