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Challenges and Barriers in Intercultural Communication between Patients with Immigration Backgrounds and Health Professionals: A Systematic Literature Review

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ABSTRACT

Challenges and barriers arise when people communicate interculturally. The situations become more complicated when patients and health professionals from different cultural backgrounds communicate with each other on the sensitive topic of sexual health. This study conducted a systematic review of past literature to identify challenges and perspectives in the intercultural communication between patients and health professionals on the topic of sexual health. The results indicate the research trends and themes generated from narrative data. Language barriers, gender, and privacy concerns of sexual health information present significant challenges in the intercultural communication between patients with immigration backgrounds and health professionals. The perspectives of patients and professionals are included in the research paper.

Introduction

Communication as a means of exchanging information between patients and health professionals plays a very important role in healthcare settings (Schiavo, 2013). Appropriate communication promotes a trust relationship between patients and health professionals, which leads to mutual understanding, satisfaction, and better health outcomes (Belasen & Belasen, 2018; Matusitz & Spear, 2014). Effective communication consists of clear, timely, accurate, and two-way interactions, accompanied by shared understanding, between patients and health professionals (Arnold & Boggs, 2015; Kourkouta & Papathanasiou, 2014). Competence in verbal and nonverbal forms of communication provides a comfortable environment for discussion and the involvement of patients in the decision-making process (Belasen & Belasen, 2018). However, in multicultural societies, there are challenges for health communication related to a lack of shared meaning, and differences in language and cultural practices. These factors can lead to misunderstanding and hinder the trust relationship (Higginbottom et al., 2015). This problem especially arises with sensitive subjects such as sexual health. In this regard, besides cultural factors, some other important variables, such as gender differences, appear. The gender of patients and health professionals has been identified as one of the main reasons for being open or closed to discussions about sexual health (Macdowall et al., 2010). This study investigates intercultural communication between patients of immigration backgrounds and health professionals on the topic of sexual health. Analysis of a systematic review of the relevant literature suggests that factors such as language barriers, gender, and privacy concerns present significant challenges in intercultural communication between patients and health professionals.

Review of the literature

Sexual health covers all aspects of sexual activity, including safe sex, prevention from diseases, reproductive health and birth control, sexuality, and sexual function. Sexual health is associated with quality of life and the human rights to privacy, autonomy, freedom, equality, and education (World Health Organization, 2017). Because sexual health is linked to the privacy of patients and usually includes a patient's sexual partner as a third person, communication can be a challenging environment for health professionals and their patients (Dehlendorf & Rinehart, 2010). Consequently, some health professionals prefer not to concern themselves with the sexual health aspects of patients, and they avoid having this discussion at all (Ho & Fernández, 2006). However, as one of the essential dimensions of mental and physical health, sexual health, if neglected, may lead to serious health consequences for patients. Past research has indicated that some diseases, such as cancer (Ananth et al., 2003; Panjari et al., 2011), cardiovascular diseases (Gandaglia et al., 2014; Pastuszak et al., 2015), and diabetes (Kizilay et al., 2017; Lue et al., 2017), can directly affect the sexual function of patients. These issues need to be discussed directly with patients and they have a right to receive comprehensive information about the effects of diseases or the side effects of treatments. However, a study revealed that health professionals often do not have enough confidence in their competence and knowledge about sexual health to be able to initiate a discussion about a patient's sexual health (Mellor et al., 2013).

Cultural values also influence communication about sexual health. Discussions about sex are often considered taboo (Agbemenu et al., 2018; Evcili & Demirel, 2018), and in some cultures, sexual health is regarded as a matter that belongs to the female domain (Alvarez-Nieto et al., 2015). As a result,

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knowledge about sexual and reproductive health is very limited in some cultural groups due to a lack of education or open discussions (Metusela et al., 2017). Feelings of shame or fear of name-calling for being sexually active can create cultural barriers that may lead to isolation and stigma (Dhar et al., 2017; Nyblade et al., 2017). Culture is a complex concept that includes beliefs, values, lifestyles, and behavior. Sexual health, which relates to behavior, is influenced by the cultural values and beliefs of the wider society (Helman, 2007). This may also create an isolating environment for sexual minority populations, such as members of the lesbian, gay, transgender, bisexual and queer (LGTBQ) community.

The health professionals not only need to facilitate communication, but also must have the intercultural awareness to establish a trusting relationship with patients from diverse backgrounds. For example, Matusitz and Spear (2015, p. 873) argue that doctors should emphasize "truth telling" and adopt a trustworthy, plain, and ethical communication style when communicating health information with patients. Recent research has adopted a constructivist and discourse-focused perspective toward intercultural communication. From this viewpoint, cultural differences are seen as co-constructed through the communication process rather than through individual cultural memberships (Zhu & Kramsch, 2016). According to Jackson (2016), intercultural communication refers to any interaction between two or more members of different cultural groups (international, interfaith, interethnic, interracial). Holliday (2018, p. 4) considers interculturality to be a "reflexive awareness of self and other in a crossing of boundaries." He opposes the essentialist view of intercultural communication and suggests that research should focus on the narratives about what happens in communication rather than "the nature of differences between national or other larger cultures." Similarly, Zhu (2020) argues that research on intercultural communication should focus on the interplay of various discourse systems, such as gender, age, profession, religion, or ethnicity. Investigating sexual health-related communication and behaviors might increase awareness among health professionals about how to practice their knowledge when they meet patients from different cultural backgrounds. Intercultural communication, as a part of health and medical education, aims to increase the students' understanding of the importance of effective communication in healthcare settings (Silverman et al., 2004). This study investigates intercultural communication between patients of immigration backgrounds and health professionals on the topic of sexual health. Numerous studies have addressed health communication and interaction between patients and health professionals. However, our knowledge about intercultural communication related to sensitive subject areas such as sexual health is very limited.

Method

This literature review study considers past research on intercultural communication between health professionals and patients about sexual health. This study adopts an integrative research approach following a constructivist viewpoint, which emphasizes narratives that illustrate what happens in communication from the findings of previous research (Holliday, 2018; Jackson, 2016; Whittemore & Knafl, 2005). The method starts with a literature search and continues with data evaluation and data analysis.

Literature search

The CINAHL, Pubmed, and Scopus were used for identifying relevant articles. Additionally, Google Scholar and StarPlus (University of Sheffield database) were used to minimize the risk of missing any valuable data related to the aim of this study. The recommendation systems of the online databases were used to locate similar articles (e.g., "people who viewed this article have also viewed the following articles," "articles of a similar topic," etc.).

The following search terms were used to search for articles: sexual health, reproductive health, sexual behavior, sexual function, sexuality, sexually transmitted, maternal health, culture, belief, value, ethnic, ethnicity, minority, immigrant, communication, interaction, physician, doctor, doctor-patient relationship, doctor-patient communication, nurse, nurse-patient relationship, nurse-patient communication, health providers, health professional, patient, client. Boolean searches (AND, OR, and NOT) were used to obtain proper search results.

Data evaluation

Among all the identified articles, original peer-reviewed articles (published in the last 15 years) were selected. Prior to the final selection, the abstract of each article was read, and the contents of each article were checked to see whether all the necessary information, such as research method, sample population, methods of analyzing data, results, and discussion, were clear and available.

Data analysis

Data analysis was performed according to the integrative method of analyzing data. This method comprises four stages: (1) data reduction; (2) data display; (3) data comparison; and (4) conclusion drawing and verification (Whittemore & Knafl, 2005).

In the first stage, all the data were divided into general subgroups and coded to organize the data. In this stage, the quantitative and qualitative data were coded separately as one and two, and similar findings received similar codes.

In the second stage, the identified codes were written and visualized in the form of matrices. This method helped to identify patterns and relationship between codes.

In the next stage, the data comparison method was applied to group the data according to themes. Finally, all the descriptions of the patterns and identified themes were provided to present the conclusion, to verify the logic behind grouping data in the form of themes, and to understand the relationship of the data to the objectives of the study.

Results

There were 290 identified articles in total, and 11 of them were selected as relevant articles for this study. The selected articles focus on intercultural communication between patients and

health professionals on sexual health. Articles not addressing the cultural dimension of communication or sexual health-related topics were excluded from this study. The selection process is presented in Figure 1. A list of selected articles can be found in the Appendix.

Publications by country

All selected studies on intercultural communication between patients and health professionals on the subject of sexual health were conducted in developed countries with a focus on female patients from immigrant backgrounds (Figure 2). This is not surprising since all listed countries are popular destinations for international immigrants.

Most participants (patients) in the selected articles had lower socioeconomic backgrounds: the majority were immigrants with Muslim backgrounds, ethnic minorities (i.e., Africans and Asian Americans). The number of articles focusing on female patients is around three times higher than those on male patients, which suggests that gender may play an important role in intercultural communication between patients and health professionals Figure 3.

Thematic analysis and comparison of the contents of selected articles

In total, three major themes were identified in this study, namely language barriers, gender, and confidentiality. A flowchart of the major themes and codes is presented in Figure 4.

Language barriers

Lack of basic language skills

Language barrier presents a huge challenge in the intercultural communication between patients and health professionals on a sexual health-related topic. Research data suggest that patients from other cultures and with immigrant backgrounds

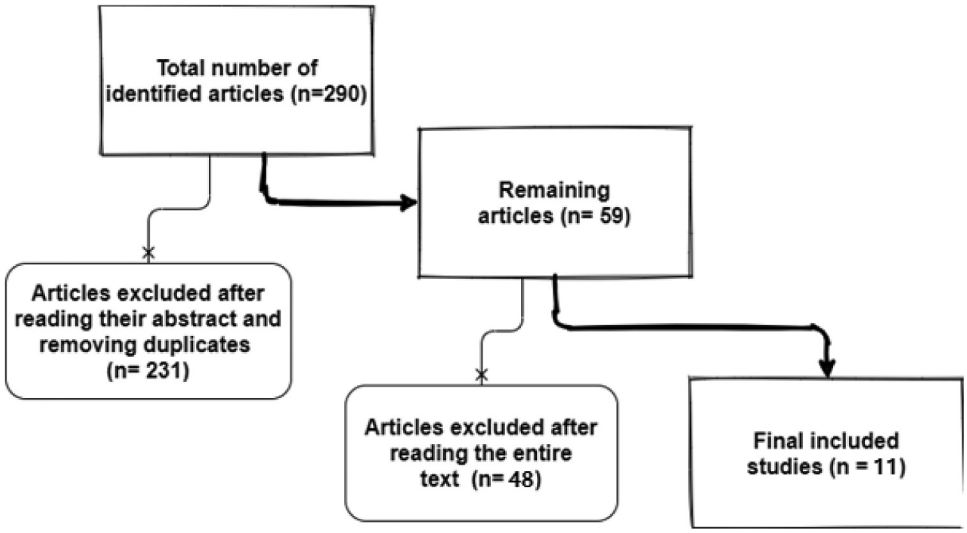

Figure 1. The process of article selection.

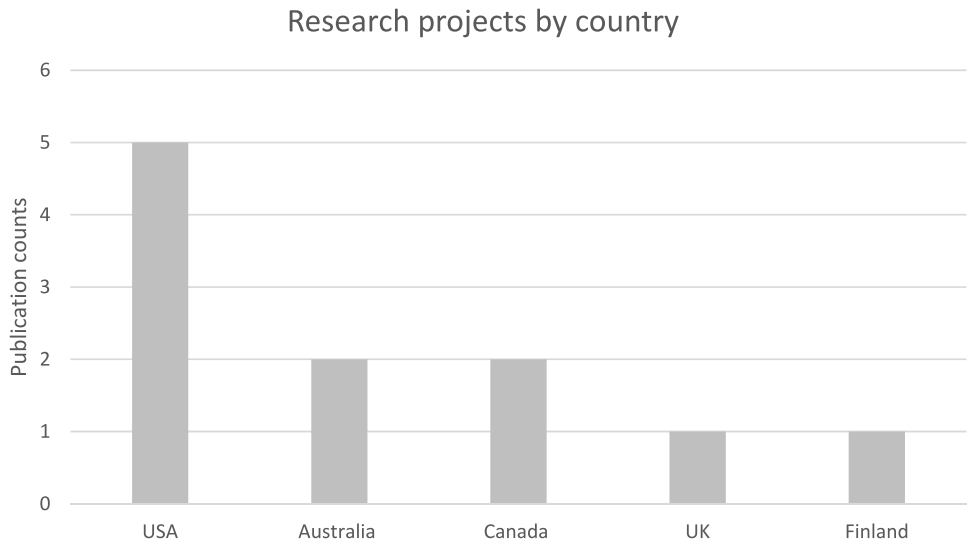

Figure 2. Publications by country.

often lack basic or everyday language command when communicating with doctors and nurses in the local language. Patients can be shy when speaking a language that is different from their mother tongue, which hinders them from getting sexual health information.

> 'They [refugee and migrant women] feel embarrassed about speaking English, which may serve to compound the fact that they are also "embarrassed to talk about their sexual health"' – *interview with a local GP in Austria (Mengesha, et al., 2018, p. 202)*

> 'Health care information accessible for people from non-English speaking backgrounds with varying degrees of literacy is fundamental in increasing SRH knowledge within minority ethnic communities' – *interview with a Women's Healthcare Worker in Australia (Rogers & Earnest, 2015, p. 228)*

> 'If they spoke to us in Spanish, they'd understand us better there' - *interview with a male patient of Hispanics Ethnic minority background in the United States (Marcell, et al., 2016, p. 406)*

Health professionals have a preference to see patients who can speak the local language. Patients who speak little of the local language can sometimes be considered illiterate even if they are fluent in another language. This can lead to misunderstanding between patients and doctors and further result in challenges to getting the patient's consent and providing them with prescriptions.

> 'If the women are illiterate, it's difficult to make sure that you have got good informed consent about procedures … I actually like people to have a basic grasp of English' – *interview with a sex therapist in Australia (Mengesha et al., 2018, p. 202)*

Lack of medical terminology

Lack of medical terminology creates another barrier to intercultural communication between patients and health professionals. Patients who possess basic or everyday language capacity in the host culture still face challenges when it comes

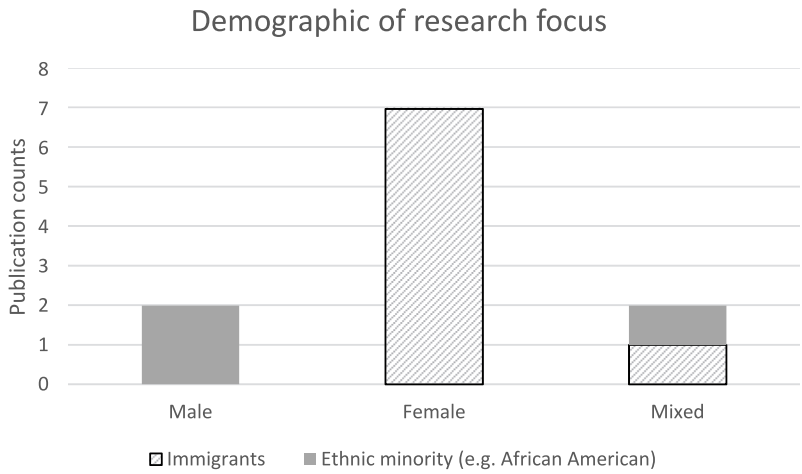

Figure 3. Publications by demographic category (gender).

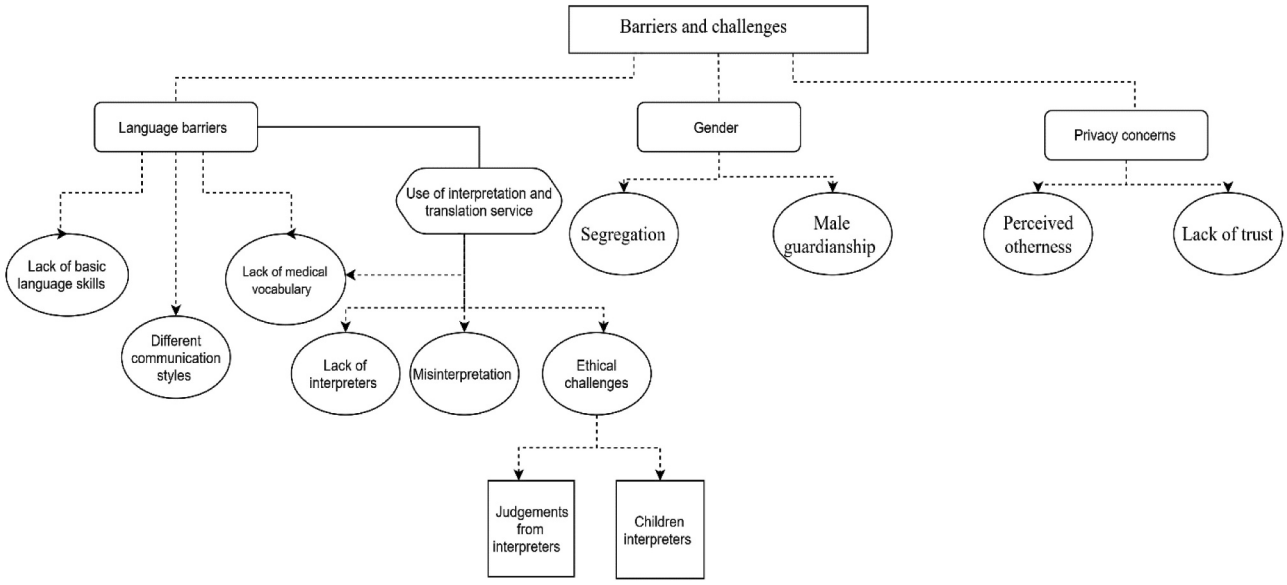

Figure 4. Data display: codes and themes.

to specific medical terminologies. Medical terminologies, such as the names of the vaccinations and diseases, are often not included in language lessons.

> 'I don't understand the names . . . the names of the vaccinations . . . they're different in my language. How can I fill out the form?' – *interview with a female patient of an African background in the United Kingdom (Shangase & Egbe, 2015, p. 22)*

> 'I have a question, what do you mean by screening? Is it a different program than when we go to family doctor and we do a check-up, we do blood testing?'-interview with a female patient of Muslim background in Canada *(Vahabi & Lofters, 2016, p5).*

Use of interpretation and translation services

Health professionals have used interpretation and translation services to support patients overcome language barriers during their consultation sessions and appointments. Although research suggests that patients and doctors have positive feedback on the use of interpretation services (Azarmina & Wallace, 2005; Joseph et al., 2017; Locatis et al., 2010), analysis of data in this paper suggests that, even when interpreters are used, there are still challenges when communicating interculturally between patients and health professionals on sexual health-related topics. It is worth pointing out that the selected literature in this research focuses predominantly on the intercultural communication of sexual health-related topics. Care must be taken to generalize these results to other populations.

Limited number of medical interpreters

Analysis of the research data suggests that there is a lack of medical interpreters when it comes to using interpretation and translation services to facilitate communication between patients and health professionals. Interpreters who are fluent in both languages may still lack the necessary medical terminology, which hinders patients from getting accurate information.

> 'While medical interpreters or translators must be educated for medical interpreter career, they must speak fluently the language of the physician and that of the patient, and must have an in-depth knowledge of medical terminology' – *interview with a male physician in Finland (Degni, et al., 2012, p. 334)*

> 'My experience with interpreters was that one of the challenges for them is that they often themselves don't understand the health language and the terms of what it means like simple things of what's a CAT scan. If a patient was needing a vaginal ultrasound they wouldn't have the faintest idea of what to say or how to explain what that is and that's a challenge' – *interview with a nurse in Austria (Mengesha et al., 2018, p. 202)*

Misinterpretation

Besides a lack of medical interpreters, health professionals and patients also encounter poor quality interpretation services. Interpreters who are not fluent in both languages may be hired to assist communication due to the high demand for interpreting services. This could result in information being misinterpreted and inaccurate diagnoses and prescriptions being given to the patients.

> 'We are frustrated because of the interpreters' poor knowledge of Finnish or inability to translate our words correctly to the women and we believe that the women were not getting the right information' – *interview with a female physician in Finland (Degni et al., 2012, p. 334)*

> 'The last appointment I had, the translator misinterpreted, so I had the wrong medicine. I started the medicine, but I stopped, because I had an effectiveness [reaction], and it was itchy, so I stopped it' – *interview with a female Somali patient in the United States (Gurnah et al., 2011, p. 343)*

Ethical challenges

There are also ethical challenges when using interpreters to assist intercultural communication between patients and health professionals. One issue involves interpreters interrupting conversations between patients and health professionals and passing on judgments. This could lead to patients feeling embarrassed to seek professional help, hence leading to delays in their treatments.

> 'and the translator stopped translating and she looked at me and she said "What do you mean? As many children as God gives her she has to take . . . " That's judgment, and I worry that the person is not going to be able to tell me what she needs . . . [I]t made me conscious that we need to train everybody specifically on that issue' – *interview with a physician in Canada (Newbold & Willinsky, 2009, p. 376)*

> 'The problem I see with interpreters is that they come from a cultural background, and if the person that is talking to you feels that that interpreter will judge them as their culture judges them, then it stops them saying things to you. So I can't get the information. It's really frustrating. It's very hard to fully be able to communicate because you've got this other person from the same culture' – *interview with a GP in Australia (Mengesha et al., 2018, p. 203)*

Another ethical challenge is that some patients who do not speak the local language would prefer to bring their children as interpreters to the consultation sessions or appointments for family support.

> 'When I take with me a son or someone who speaks my language, they never accept this person. That is the main problem. The translator may tell me about medication, but I don't know what it is. I don't know if that is true or not, or if the translator is mistranslating, because I don't understand what the translator is saying [and] I don't understand the English' – *interview with a female Somali patient in the United States (Gurnah et al., 2011, p. 343)*

Although the children speak the local language more fluently than their parents, the age inappropriateness and the sensitive nature of sexual health topics present a huge challenge for health professionals as to what can be asked of the children to interpret. Also, a lack of understanding and knowledge in sexual health due to the young age of the interpreters can lead to misinterpretation in the conversation.

> 'The more frustrating and hopeless situations are the use of these women's 8 to 10 years old kids or 11 to 16 years old teenagers, who compared with their mothers speak better Finnish but do not know what we are really talking about. It is so difficult to tell a kid what he or she does not understand or should not know. We could never be sure if the kid understood and reported the right thing to the mother' – *focus group interview with nurses in Finland (Degni et al., 2012, p. 336)*

'You find this dysfunctional pattern where they bring the child as an interpreter. The child is Canadianised and they speak English very well. But, because of their age it is inappropriate for them to ask the parents some sorts of question, so if you ask the questions, the child will sort of look at the parent and not talk to them and sort of answer for them . . . And sometimes it is just plain inappropriate to be talking to the parent about the kinds of things we are talking about when you have a child there' – *interview with a nurse in Canada (Newbold & Willinsky, 2009, p. 375)*

Communication style

Besides language barriers, different styles of communication between patients and health professionals from different cultural backgrounds can lead to misunderstanding and impact negatively on trust-building. Patients from cultures where "small talk" or socialization is considered an essential role in establishing a trust relationship might find it challenging when communicating with health professionals who prioritize professionalism and efficiency in a work environment.

'I must say that, we do not have time to socialize or have special relationship with our patients, not even with our Finnish patients. The Somali women must understand as we say in Finland "maassa maan tavalla" in English "when in Rome, do as the Romans do". Our work is to provide good health care when they come to our clinics and not to gossip with them' – *interview with a female physician in Finland (Degni et al., 2012, p. 335)*

'It's the comfortability that's the most important. How comfortable I am with you is how much I'm going to divulge. And it's never been asked. You know, and I've had to change counselors because I was uncomfortable with this one' – *interview with a male patient of African background in the United Kingdom (Saleh et al., 2011, p. 527)*

Gender

Data analysis in this research suggests that gender plays an important role in intercultural communication between patients and health professionals on sexual health-related topics. Gender segregation due to cultural traditions and religious beliefs can create huge barriers between female patients and male health professionals. Gender also has an impact on patients' decision-making as some patients with immigrant backgrounds may be influenced by the male guardianship system.

Segregation

Gender segregation due to religious beliefs and cultural traditions may present intercultural communication challenges between patients and health professionals. Research data suggest that female patients from cultures with gender segregation report feeling uncomfortable to be seen by male doctors or nurses. This could lead to patients refusing to turn up for scheduled appointments, to the delay of treatments, and to the waste of medical resources.

'I wouldn't talk to them [male doctors]; I just wouldn't feel I could' – *interview with a female patient aged 35 from an African immigrant background in the UK (Shangase & Egbe, 2015, p. 22)*

"All the Muslim women have concerns about seeing the lady doctor. It is easier to talk about our gynecologist problems or our breast problems, or other problems [. . .] For my gynecologist, I wait for six months. Yeah

because I need a lady doctor and she doesn't have the time [. . .]."- *interview with a female patient of Muslim immigrant background in Canada (Vahabi1 & Lofters, 2016, p. 7)*

'She was told the male doctor was going to check her. She refused it. She missed 3 appointments for that. They said they will not give her any more doctors; they are enforcing her to do it. . . . She is still sick' – *interview with a female Somali patient by a translator in the United States (Gurnah et al., 2011, p. 343)*

Gender segregation presents an intercultural communication challenge not only between patients and health professionals but also between patients and interpreters. Female patients might refuse to share information in front of a male interpreter. Male interpreters can also feel uncomfortable and be reluctant to interpret information regarding female sexual health issues.

'[with male interpreters] women generally close up and you can't get anything out of them'; 'I think working in women's health – often, interpreters can be male, and that can present a challenge because a lot of women don't feel comfortable talking to men' – *interview with two nurses in Australia (Mengesha et al., 2018, p. 203)*

'Quite recently I had a lady who was coming for an IUD assessment and we had a male interpreter. I was trying to explain the procedure for the IUD insertion. We had to explain it about five or six different times. I think it was just that the male interpreter wasn't comfortable with talking about a vagina and a cervix and a uterus. The lady just wasn't understanding where these placements were, even though I was – as I was explaining, and as he was explaining, I was pointing to them on a diagram as well' – *interview with a nurse in Australia (Mengesha et al., 2018, p. 203)*

The gender segregation of patients' home cultures can also lead to misunderstanding between the patients and health professionals. This can result in negativity on both sides, especially from male healthcare practitioners.

'I felt insulted and humiliated when the nurse told me that a patient said she does not want to come to the examination because I am a man. Her attitude was a shock to me, but there was nothing to be done about it, so I accepted it' – *interview with a male physician in Finland (Degni et al., 2012, p. 337)*

Male guardianship

Gender has an impact on the intercultural communication process between patients and health professionals as well as on the decision-making process of patients who are influenced by a male guardianship system. This presents challenges regarding informed consent and can potentially delay treatment.

'One day, the husband came with his wife into the examination room to see what I was doing' – *interview with a male physician in Finland (Degni et al., 2012, p. 337)*

'The other problem we are facing with the large majority of these women is that it is the husband who has the final word on the wife's informed consent. Sometimes, specific gynaecological investigation

problems are difficult or take time to be solved, because we have to wait for the husband's approval' – *interview with a male physician in Finland (Degni et al., 2012, p. 337)*

Privacy concerns

People may have different perspectives on confidentiality when it comes to communicating interculturally. This can have a great impact on the interaction between patients and health professionals, particularly on sexual health-related issues.

Perceived otherness

Patients consider that it is acceptable to share private information with family members as a way of getting family support. However, health professionals in the host country may view patients individually and consider that sharing a patient's information with his/her family members is a breach of confidentiality.

'When a Somali woman comes to the medical examination, she does not come alone but with all the family, so there is no privacy. You cannot tell her personal things or you do not know what to tell her, because you do not know if she wants all family to hear what you are telling her' – *interview with a female physician in Finland (Degni et al., 2012, p. 337)*

Trust

Research data suggest that patients show low trust in health professionals in the host country; in particular, they are concerned that their private information may be leaked out by practitioners, nurses, or interpreters to their local communities.

'Sometimes you will see a client who does not want to work with an interpreter, especially in small communities there are limited numbers of interpreters from that community. The client may know the interpreter or know people who know the interpreter and they will worry about confidentiality. That causes a lot of embarrassment for women. They will try to struggle with the language and do without the interpreter because they don't want that' – *interview with a GP in Australia (Mengesha et al., 2018, p. 203)*

'It was [my husband], me and the doctor, the only three that knew … so I ask her [mother-in-law] "how did you find out?" Well, I imagine the doctor mentioned it to someone and that someone mentioned it to someone else and they found out. That is why now I am more discreet' – *interview with a female Mexican patient in the United States (Espinoza et al., 2014, p. 361)*

Some young adults worry that their confidential information may be passed onto their family if they use a family doctor. This could lead to vulnerable young adults prioritizing peer support or online information over seeking professional help.

'I always go to the Internet first for confidentiality. I know this is anonymous, but I recently contracted an STD, which is a really common one that one in four women have. I was freaking out and I didn't know what to do and I needed a confidential source, so I read more articles than was good for me on the Internet, and it really gets in your head' – *interview with a young Asian female patient in the United States (Frost, et al., 2016, p. 11)*

Discussion and implications

This study conducted a systematic review of the literature to identify challenges and perspectives in intercultural communication between patients and health professionals on the topic of sexual health. The results suggest that current literature around intercultural communication on sexual health largely focuses on patients from less privileged socioeconomic backgrounds (e.g., refugees, asylum seekers, immigrants, and ethnic minorities) living in developed countries. Major themes that can impact intercultural communication between patients and health professionals are language, gender, and privacy concerns.

A lack of basic command of the local language and medical terminology by patients from migrant backgrounds prevents them from actively seeking information and getting timely treatment. Different styles of communication can create misunderstanding between patients and health professionals. "Small talk," which is considered important by patients for establishing a trust relationship, may be considered as time-consuming and unprofessional by health professionals. This finding is consistent with that of Higginbottom et al. (2015) who suggest that differences in language and cultural practices could lead to misunderstanding and hider trust-building between patients and health professionals. To overcome these language barriers, hospitals have hired interpretation and translation telephone services. However, our data suggest that these interpreting services employed by health professionals to facilitate communication also presents pitfalls. The interpreters although are fluent in everyday communication still lack medical vocabulary. Moreover, the use of unqualified interpreters may present significant ethical challenges, such as interpreters becoming judgmental toward patients. In some cases, due to a lack of interpreters or patients' concern over privacy, underaged children have been used as interpreters to discuss sexual health-related issues of their parents with health professionals. These present further barriers as the low accuracy of translation and the age inappropriateness of the interpreters on sexual health topics. The results of the data analysis indicate that there is a need to safeguard the quality of the interpreting service providers and to employ medical interpreters who understand medical terminologies and have received proper ethical training so that misinterpretation of information is minimized.

Gender segregation due to cultural traditions or religious beliefs creates another intercultural communication barrier between female patients and male health professionals. This finding is in accord with the study by Macdowall et al. (2010) indicating that gender of patients and health professionals greatly impact the openness of the discussions about sexual health. Our results suggest that female patients reported feeling uncomfortable about being open with or seeking advice from male doctors, nurses, or interpreters. Male practitioners reported feeling insulted when female patients refused to be examined by them. This could also lead to female patients refusing to attend their scheduled appointments, which further results in delayed treatment and the waste of medical resources. The decisions of patients (e.g., consent) can also be

influenced by gender, particularly in contexts where a cultural tradition of male guardianship is a factor, and this further complicates the issues of gender segregation.

Moreover, concerns over privacy present another challenge in communication. Analysis of data suggests that patients consider family as a unit and would trade off their privacy for family support. This presents a challenge for health professionals who consider sharing a patient's information with his/her family members to be a breach of confidentiality. This is in line with previous research which highlights the challenges faced by health professionals when communicating private information to patients who bring in their family or support groups (Dehlendorf & Rinehart, 2010; Zhao & Brown, 2017). Our results also suggest that patients have low trust that health professionals and interpreters will keep their sexual health information confidential. They exhibited concern that family doctors and community interpreters may leak their information to their friends and relatives within their communities.

Limitations and recommendations for future research

The generalizability of these results is subject to certain limitations. The analysis is based on a small number of selected papers focusing on narrative data. The topic of the project is specific to intercultural communication on the topic of sexual health. In spite of its limitations, the study certainly adds to our understanding of the challenges and perspectives in intercultural communication between patients of immigration backgrounds and health professionals. Language, gender, and confidentiality of information were found to play major roles in the intercultural communication process. Suggestions for future research directions include studies to further explore these identified areas with the aim of enhancing intercultural communications between patients with immigration backgrounds and health professionals. Further studies can also include quantitative data to expand and validate the results of this study.

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Appendix

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