Perspectives of junior doctor intercultural clinical communication: Lessons for medical education

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Abstract

Introduction: Increasingly, junior doctors are culturally diverse due to globalisation of the tertiary education system and health workforce shortages. These graduates deliver healthcare where a proportion of the population may not have the English language skills to communicate effectively. The aim of this study was to examine perspectives of junior doctor–patient communication in a culturally diverse setting.

Methods: We adopted a qualitative design with focus group discussions with junior doctors and semi-structured interviews with senior hospital staff at one regional hospital in Australia. We asked participants to discuss challenges and enabling strategies. There were five focus groups with 20 junior doctors and interviews with 10 senior doctors and 4 senior professional staff. Data were analysed thematically.

Results: The two major themes to emerge in the discussion with the junior doctors were their own and the patient's language as a barrier, and cultural influences on healthcare communication. The subthemes for language as a barrier were fluency, impact and mediated communication. The subthemes for cultural influences were uncertainty and cultural comfort. The results of the semi-structured interviews with senior clinical and hospital staff identified similar themes, yet the focus was on the junior doctors' language ability, their ability to understand and engage with the needs of "country" people and their ability to explain complexity.

Discussion: The findings suggest that intercultural communication is multi-faceted and intrinsically challenging, confirming the need for intercultural communication in medical curricula, particularly teaching that makes reference to culturally and linguistically diverse patients as well as cultural diversity in the medical workforce.

Keywords: intercultural communication; junior doctors; mediated communication; CALD patients.

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Introduction

Cultural diversity and communication in contemporary healthcare

In Australia, as in many Western countries, increasingly, junior doctors, including international medical graduate (IMG) doctors and medical students, are culturally diverse due to factors such as globalisation of the tertiary education system (Hawthorne, Minas, & Singh, 2004) and health workforce shortages (Australian Government Department of Health, 2008; Mullan, 2005). Australian junior doctors include Australian-born graduates, overseas-born Australian graduates and IMGs (Hawthorne et al., 2004) working in a healthcare setting where international medical migration is set to continue (Hawthorne, 2012). While there is a body of literature on the communication needs of culturally and linguistically diverse (CALD) clinicians (Cross & Smallridge, 2011; Dorgan, Lang, Floyd, & Kemp, 2009; Fiscella & Frankel, 2000; Hall, Keely, Dojeiji, Byszewski, & Marks, 2004; Roberts, Sarangi, Southgate, Wakeford, & Wass, 2000; Woodward-Kron, Fraser, Pill, & Flynn, 2014; Woodward-Kron, Stevens, & Flynn, 2011; Zulla, Baerlocher, & Verma, 2008) and medical students (Hawthorne et al., 2004; Liddell & Koritsas, 2004; Niu et al., 2012; Woodward-Kron, Hamilton, & Rischin, 2007), medical educators seldom investigate or conceptualise communication in healthcare settings where cultural and linguistic diversity is commonplace amongst doctors, medical students and patients. In migration and refugee destination countries, such as Australia, a significant proportion of the population may not have the language skills to communicate effectively in English about their health needs. For example, more than 25% of the population in the state of Victoria speak a language other than English at home (Australian Bureau of Statistics, 2013).

The ability to communicate effectively with patients from different language and cultural backgrounds is acknowledged internationally as a desirable graduate attribute (Kachur & Altshuler, 2004; Kiessling et al., 2010; Skelton, Kai, & Loudon, 2001; von Fragstein et al., 2008). A number of studies report curriculum innovations to prepare students to practise in culturally-diverse settings and to become culturally competent (Betancourt, 2003; Kachur & Altshuler, 2004; Kai, Bridgewater, & Spencer, 2001; Kai, Spencer, & Woodward, 2001; Pasricha, 2012; Rosen et al., 2004; Tang, Fantone, Bozynski, & Adams, 2002; Yau, Woodward-Kron, Livesay, Elliott, & Nicholson, 2016). These studies highlight the ongoing need for medical curriculum developers to incorporate communication training for culturally diverse healthcare. Many junior doctors become trainees in inner city hospitals where mediated communication through interpreters is common (Malhotra et al., 2009). Malhotra et al. pointed out that one barrier to the transfer of communication skills is the cultural homogeneity of simulated patients compared to the cultural and social diversity of patients they encountered in their training environments. These doctors also reported miscommunication due to language barriers and different cultural expectations of healthcare (Malhotra et al., 2009). There are also health disparities for migrant and ethnic minority groups in Western societies due to factors beyond the language barriers, such as differing health beliefs and expectations of care, access to services and other social determinants of health (Bollini & Siem, 1995; Henderson, Kendall, & See, 2011). This is the case in Australia, emphasising the need for culturally effective healthcare communication (National Health and Medical Research Council, 2005; Woodward-Kron et al., 2016).

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Aim

The aim of this study was to investigate junior doctor and senior staff perspectives of junior doctor intercultural communication in a setting where patient and staff cultural diversity is common. It was hoped that the findings could provide insights, for medical education, into the gaps, challenges and enabling strategies that junior doctors adopt when providing healthcare in culturally diverse settings. We use the term "intercultural communication" to refer to the healthcare interaction, where potential for misunderstandings can be played out, for example, due to differences in participants' health beliefs, language barriers or different cultural approaches to the doctor–patient interview (Roberts, 2007). While the term cultural competence is prominent in medical education (Godkin & Savageau, 2001; Kachur & Altshuler, 2004; Pasricha, 2012) and healthcare policy documents (e.g., National Health and Medical Research Council, 2005), its focus is mainly on health professionals becoming culturally sensitive. Cross-cultural communication tends to be used more broadly to refer to issues arising due to differences in language and cultural backgrounds of patients and staff (Betancourt, 2003; Skelton et al., 2001).

Methods

We adopted a qualitative design, conducting focus groups with junior doctor participants (Group 1) and interviews with senior clinicians, administrative and management staff at one hospital (Group 2). While it was not feasible to interview patients, we interviewed administrative staff (Group 2) from the hospital's quality unit to gain insight into patient experiences. The researchers included four interns from the participating hospital.

Setting

The study was undertaken at Goulburn Valley Regional Hospital, a teaching hospital in Shepparton, Victoria, Australia. Shepparton has a history of welcoming refugees and migrant settlers, and it is also home to a large indigenous population. The Islamic population is the fastest growing religious group. The hospital has implemented a range of measures to address the needs of the local population, including a cultural responsiveness plan (Goulburn Valley Health, 2012). The hospital's workforce is culturally diverse. It has a yearly intake of approximately 28–30 interns, that is, junior doctors in their first year of training. In recent years, the interns have been predominantly Malaysian with both Chinese and Malay backgrounds.

Participants and recruitment

There were two groups of participants. The first group was the junior doctor participant group. The junior doctors were interns and Postgraduate Year 2 junior doctors, including IMG doctors with limited registration. Participants were recruited with the assistance of the medical education officer. Participant characteristics are provided in Table 1. Four interns were co-researchers.

The second group included clinicians, administrative staff and managers who were involved in the supervision and training of junior doctors. Recruitment was purposive: we sought a range of perspectives from different clinical settings in which junior doctors trained as well as from administrative units where staff had direct or

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indirect contact with junior doctors. Table 2 shows the participant characteristics. The study had ethical approval from the Goulburn Valley Health Ethics and Research Committee (ID: GVH 07/12).

Table 1
Junior Doctor Participants (n = 20), Group 1

	Male	Female	Total
Australian born, medical education in Australia	0	3	3
Overseas born*, medical education overseas	2	1	3
Overseas born*, medical education in Australia	3	3	6
Overseas born*, medical education at an Australian offshore university	1	0	1
Overseas born*, overseas AND Australian medical education	4	3	7

*Overseas-born participants: regions of origin were Southeast Asia (13), UK (1), Africa (2)
Six of the participants born in Southeast Asia identified English as their first language.

Table 2
Characteristics of Senior Clinicians and Hospital Staff (n = 14), Group 2

	Australian born	Overseas born*	Medical education in Australia	Medical education overseas	Male	Female
Clinicians (n = 10)						
Senior medical officer (ED)	x		x			x
Medical clinical educator/ consultant surgeon	x		x		x	
Senior medical registrar		x		x	x	
Consultant physician		x		x	x	
Consultant physician	x		x			x
Academic/consultant physician	x		x		x	
Senior medical officer (ED)		x	x		x	
Senior medical officer (ED)		x		x	x	
Consultant physician		x		x	x	
Senior medical officer (ED)		x		x	x	
Total	**4**	**6**	**5**	**5**	**8**	**2**
Administrative/Management Staff (n = 4)						
Medical education & workforce		x				1
Health information services	x					1
Quality of care	x					1
Goulburn Valley Foundation	x					1
Total	3	1			0	4

*overseas-born participants: regions of origin were Africa (3), Southeast Asia (2), Eastern Europe (1)

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Focus group discussions with the junior doctors (Group 1)

Focus groups can facilitate communication between research participants, providing opportunities to explore shared experiences (Kitzinger, 1995). The intern co-researchers conducted the focus group interviews in order to minimise the distance between the researchers and participants. The development of the focus group interview schedule was informed by the insights of the intern co-researchers. The emergency department (ED) was given as the main context for discussions, as acute patient presentations combined with cultural and linguistic differences can lead to serious communication problems (Garling, 2008). Furthermore, all Australian interns complete an ED rotation.

We began the interview by stating our understanding of intercultural communication in healthcare, then asked participants to reflect on their skills of conducting the medical interview when communicating with culturally and linguistically diverse (CALD) patients. To elicit challenges and enabling strategies, we asked participants to narrate an episode of effective intercultural communication as well as a less effective interaction. Five focus group discussions of 50 to 60 minutes' duration were conducted in mid-2012 with 20 junior doctor participants in total. The discussions were audio-recorded and transcribed. The interviews were transcribed as soon as possible after the interview took place, which was between 1 and 2 weeks. The transcripts were checked for accuracy by the interviewer(s) and anonymised.

Analysis

The thematic analysis was conducted in several stages: the researchers familiarised themselves with the transcripts, then met for an initial discussion of the themes emerging from the interviews. The initial analysis of themes and subthemes for each focus group was undertaken together by the researchers who had conducted the focus group. These themes were discussed at a second meeting with all researchers, and themes were defined. Where there was disagreement or ambiguity, further examination of the interview data was carried out and there was discussion until agreement was reached. The University of Melbourne (UoM) researchers reviewed and finalised the themes and subthemes as a further quality measure in preparation of this manuscript.

Semi-structured interviews with senior clinical and hospital staff (Group 2)

The UoM researchers interviewed senior clinical and hospital staff either in person or by telephone. We chose semi-structured interviews as the most appropriate form of interview, as they allow for exploration of issues that emerge throughout the interview whilst still containing enough consistency to allow for comparability (Kitzinger, 1995). The interview outline had a similar structure to the junior doctor focus group interviews. The interviews were between 15 and 60 minutes' duration.

Results

Two broad shared themes emerged for both the junior doctor group and the senior clinical and hospital staff group. The results for both groups are reported separately in order to explore their points of difference and similarities in more depth.

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Focus group discussions with junior doctors (Group 1)

The two broad themes to emerge from the junior doctors were "language as a barrier" and "cultural influences on healthcare communication".

Language as a barrier

The theme language as a barrier refers to the linguistic barrier when communicating with culturally and linguistically diverse (CALD) patients to understanding patients who used Australian slang, in addition to language as a barrier between overseas-born senior doctors and their patients. The interrelated subthemes were fluency, impact and mediated communication.

When patients had minimal English language skills, this impacted all aspects of communicating about their care. The junior doctors reported that some patients were unable to provide responses to simple questions about the presenting complaint, and the junior doctors felt constrained in the depth of the details they could give the patient about their symptoms, diagnosis and management.

> *And this patient had a really big cancer up here [pointing to forehead]. And I asked a very simple question, "How long have you had it?" and he can't even answer that question. Is it painful?" … That was a really bad experience.* (Group 1, female, Australian born)

> *You can find out, for example, whether they've had diarrhoea, but you can't find out whether there was mucous and blood in it. … Do you know what I mean? I mean, like the details that go into, that we're expected to take a good history, maybe you can't get those details.* (Group 2, female, Australian born)

To mitigate against these factors, the junior doctors reported a number of strategies, including using their smart phones to access Google Translate, drawing diagrams, simplifying explanations, using brochures or Internet sourced follow-up information, as well as advising patients to follow up with the pharmacist and "see your GP" (Group 2, female). Several commented on their awareness of the potential for a language barrier based on patients' appearance or last name, with one participant mentioning "a long unfamiliar un-Caucasian surname … like me" (Group 1, male). Subsequently, they engaged the patient in small-talk in order to gauge the patient's understanding of English and to tailor their talk.

Australian English in the rural setting initially posed challenges for some overseas-born doctors' comprehension, and some reported that they assumed slang was used only for conversation and was not important. These doctors showed awareness of the challenges their accents might cause patients. The Australian-born junior doctors also reported patients seeking their input to understand some of the overseas trained senior doctors.

> *Initially, I found it hard in a rural setting to understand certain terms. I remembered patients saying, "I'm feeling crook." I think it's important to ask patients to clarify that. I think patients know I'm not from around here due to my skin colour.* (Group 5, male, overseas born)

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> *Because they are elderly, they are not used to this multicultural, multilingual, multi-accented society, so when you don't speak to them in an Aussie way, they just don't catch you, that's why, and this is especially true in Shepparton because three-quarters of our patients are elderly.* (Group 2, female, overseas born)

> *Sometimes when a consultant rounds, and they have a bit of an accent, after he leaves the patient will say, "What did he say? I didn't catch a word of that."* (Group 3, female, Australian born)

Mediated communication was discussed in the context of barriers to communication rather than enabling effective care. While the discussion reflected participants' understanding of the principles of including professional interpreters in patients' care, much of the discussion focused on access to telephone interpreters in the ED. Junior doctors reported acting as interpreters for the care of other doctors' patients as well as drawing on the language skills of senior colleagues. Participants acknowledged the importance of interpreters and their under-utilisation.

> *I think it's still ok if you have a speaker with a phone interpreter, but the worst one is that they have to get the thing and pass it on to the patient. No idea what they have been talking about for like 2 minutes. And then the interpreter comes to say, "No."* (Group 3, male, overseas born)

> *Sometimes if it gets too hard to communicate then you are going to call in the cavalry and get an interpreter.* (Group 1, male, overseas born)

> *I think we are totally under-utilising the interpreters in every area; we go, "It's too hard, just trust the family, and fingers crossed."* (Group 1, female, Australian born)

Cultural influences on healthcare interactions

The theme "cultural influences on healthcare interactions" refers to patients' values, beliefs and behaviours that the junior doctors attributed to patients' cultural and ethnic backgrounds. This theme includes religion and gender aspects that were seen to impact on healthcare interactions, orientation and expectations about doctor–patient interactions and "cultural comfort". A subtheme is uncertainty, such as "*I didn't really know what to do*", which occurred throughout the excerpts relating to this theme. The quote below illustrates this theme, where the elements of religion, expectations of female modesty, language and mediated communication through a family member, as well as the doctor's inexperience combine. Expressions of uncertainty such as "I didn't really know what to do" were common (highlighted in bold in the quotes).

> *One of the worst cases of miscommunication I have seen so far was this lady. She was Muslim, and then she had some sort of vaginal problem, and she couldn't speak English but the husband could and so the husband sort of took control of the interview. … I asked her, "Are you in pain?", and it was sort of,* ***and I think*** *she was trying to say having more than she was letting on but then the husband was, "She's fine; she's fine" [sighing]. Then* ***I wasn't quite sure how to proceed****. I could talk directly to her; it would mean putting the husband out of the way. And then there was a whole language barrier, and* ***that was one of those things. I didn't really know what to do.*** (Group 1, male, overseas born)

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The junior doctors noted differences between how Australian patients interacted with doctors and how some CALD patients approached the medical consultation. These differences were attributed to CALD patients' experiences of a more hierarchical paradigm of doctor–patient interaction; patients reportedly asked fewer questions. Junior doctors noted differences about how pain was expressed. Another reported difference was CALD patients' health knowledge. The junior doctors commented about the limited assumptions they could make about these patients' health literacy. Conversely, a related subtheme was "cultural comfort" or familiarity. This refers to the junior doctors' cultural backgrounds reportedly assisting with establishing rapport with patients from a culture broadly aligned to their own as well as their cultural knowledge. Australian-born junior doctors reported ease with patients from cultural backgrounds different to their own.

> *I tried to explain that "chole" procedure [cholecystectomy] to an African refugee, and the father-in-law was there as the interpreter. I thought . . .* ***I don't know*** *about their background, their culture, their level of education … so it's hard. … In the consent form, they wrote cholescystitis. In the end, the father-in-law and the patient asked me, "So what exactly are they going to do?" . . . I still had to explain the procedure to the best of my knowledge. It was hard because they were like, "Stone? Kidney stone?" and I said, "No, gall stone." No idea what a gall stone is, what a gall bladder is. It was hard.* (Group 4, male, overseas born)

> *But it's a pretty pertinent point. Education is … I mean every Australian has to undergo a certain level of education and with people coming from different countries, you don't know what their level of education is. Or they've never been schooled and been a farmer, and you don't know. So if you explain to a white person, like white people on Dr Phil and all the rest, there's always like, health issues, heart attack. People discuss these things in our culture and have a fair understanding … and* ***I don't know*** *what's done in other cultures and whether people know where the lungs are in the body or the kidneys, or even what they are. Like, you know,* ***you just don't know****.* (Group 4, female, Australian born)

Semi-structured interviews with senior clinical and hospital staff (Group 2)

The major themes to emerge from the semi-structured interviews with senior clinical and hospital staff were also language as a barrier and cultural influences on healthcare communication, whereas the subthemes differed from those that emerged from the junior doctor focus groups. Minor themes were clinical skills, including communication and patient education and counselling. The description is limited to the two main themes due to space constraints.

Language as a barrier

The senior clinical and hospital staff reported language as a barrier from several perspectives. Overseas-born junior doctors' unfamiliar accents were a barrier to understanding for patients; these doctors' unfamiliarity with Australian vernacular was, likewise, a barrier, as junior doctors were unable to provide clinical explanations that resonated with the patient's own language and understanding and struggled to explain complexity to their patients. The participants differentiated between overseas-born

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and Australian-trained junior doctors, and IMGs who had come directly to Goulburn Valley Health to take up employment, with the patients reportedly experiencing the most difficulty with IMGs.

> *Even if they are Australian trained, sometimes I might find they are still struggling with conversation. Or it could be their accent could be affecting the quality of the communication with the patient, who may not be that familiar with listening to that language.* (medical education, overseas born)

> *Well, they are definitely most of them English is not their first language, so they might not be very fluent, but they do have effective communication. But I agree there is room for improvement for their own sake and for the sake of the patient. … Patients have complained when they haven't understood the doctor. What I was getting from the patient was entirely different from what the junior doctor was telling me.* (consultant, overseas born and educated)

While the junior doctors acknowledged their unfamiliar accents and initial lack of understanding of idioms, they also felt that they had sufficient strategies to overcome any miscommunication. The senior doctors, however, pointed out that both accent and lack of ability to use vernacular language to aid patients' understanding restricted how well the junior doctors could address the patients' information needs and points of view.

> *Often the IMGs who come out from overseas and come straight here, it's very difficult and you see that often the patients can't understand them. They don't quite get there as far as communicating, you know, what's going on and what the patient needs. … They don't quite deal at the same level. When you talk to patients, they indicate that as well. They couldn't understand the doctor. They didn't quite "gel" sometimes.* (senior medical officer, ED, Australian born and educated)

> *I think with some accents [it] is a problem. It can be quite heavy, and some patients have considerable difficulty understanding exactly what the person is saying. … I think it's a skill set problem and lack of appreciation of the other person's point of view.* (medical educator/consultant, Australian born and educated)

Enabling strategies reported by the senior doctors included Australian patients' awareness of the need to adjust their language "because doctors in the ED aren't primarily Aussies".

> *Australian patients are very willing to explain in a language that doctors from overseas can understand because Shepparton is multicultural, multiracial, so patients know that doctors in the ED aren't primarily Aussies so they adjust their language.* (senior medical officer, ED, overseas born and educated)

In contrast to the junior doctor findings, mediated communication was reported to be an enabling strategy and drew on the language skills of senior doctors, junior doctors, nurses and patients' families in order to achieve the common goal of providing the patient with effective care. There was a concern amongst a number of the senior clinical and hospital staff that the junior doctor cohort lacked the language skills to properly explain complexity to patients, particularly if there were linguistic or cultural barriers.

> *They are ok on the simple things, but the more complex things … They're the hard ones for the interns.* (senior medical officer, ED, Australian born and educated)

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There was also concern that the information that senior doctors gathered from patients during the review process could be "entirely different from what the junior doctor [had reported]". (senior medical officer, overseas born)

Cultural influences on healthcare interactions

For the senior clinical and hospital administrative and management staff, cultural influences on healthcare included the geographical setting, as it was seen to shape patients' behaviours and needs. Subthemes were caring for "country" people, religion and gender, and paternalistic models of care. Respondents commented on prejudicial attitudes of some Australian-born, monolingual Caucasian people towards overseas-born doctors from non-English speaking backgrounds. The success of an interaction could rely on the "cultural comfort" of the patient. An overseas trained doctor provided reasons for these prejudicial attitudes based on his own transition and acceptance into the community. This excerpt highlights the benefits to be gained from overseas-trained junior doctors acquiring a better understanding of country patients' lives, including the challenges of seasonal work, farming, distance and impact of healthcare shortages.

> *The patients are a little bit different in the rural setting; in some ways, their attitudes are a bit different. I suppose the patients are … we have such a broad range of nationalities here. There is a big range of different patients, which I suppose in Melbourne may be the same as well depending what hospital you're at. But often the Caucasians have fairly sort of set views unfortunately. In Shepparton, I know that that's true. They can be fairly sort of anti doctors of other races, you know. You have to deal with that attitude as well. Often, it's not always the doctor who may be an IMG um who is struggling to deal with the patient; the patient may not want to have to deal with the non-English origin doctor. So sometimes it's the attitude of the patient which cannot help the doctor. And that's often worse in the country, I think*. (senior medical officer, ED, Australian born and educated)

> *The rural people, they are a bit different. I'll tell you, I was a GP when I started. I was their doctor; I would go and visit their homes and so on. … It takes time in a rural community to get to know and to be trusted. I was fine because I was their doctor. That's the kind of thing, I've been here a long time and I know everyone. And I go on the street, and they say to me, "Can't you find some doctors who speak English" [laughing]. And I say, "I'd love to," but this is what we are working with. It's what we have. And if the doctor does the wrong thing, he can't get the right connection. But if the patient does have some preconceived idea and doesn't give the right information, you end up with the same point. But people don't really appreciate that [laughter], so you know. And the people in the countryside, they are a bit more conservative in a way; it takes time to adapt to change.* (senior medical officer, ED, overseas born and educated)

Discussion and conclusions

The findings of this study into junior doctor, senior clinician and staff perspectives of junior doctor communication in a culturally and linguistically diverse rural healthcare setting suggest that intercultural communication is multi-faceted and intrinsically challenging. The challenges of intercultural communication have implications for how

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clinical information is effectively exchanged between doctor and patient. It also emerged that intercultural communication with its inherent potential for misunderstandings and repair is ubiquitous in this clinical environment. To counteract this, junior doctors appear to have developed a range of strategies to overcome these barriers, including awareness of appropriate communication and resourceful use of technology and other colleagues' language skills, as well as other health professionals in order to compensate for gaps in understanding and management. The findings also suggest that the junior doctors mobilise these resources as well as their language skills in order to provide the best possible care for all patients. The extent to which these strategies are successful warrants further study.

The finding that language can be a barrier to the effective exchange of health information echoed previous studies that identify accent and vernacular usage of both the locally-born patients and the overseas-born doctors as a barrier to understanding (Dorgan et al., 2009; Hall et al., 2004). In addition, the perspectives of the senior doctors suggest that there are missed opportunities for more effective exchange of health information when junior doctors are unable to engage with locally-born patients using the language and idioms with which they are more comfortable and familiar. Conversely, this study sheds light on challenges that overseas-born doctors may face when patients lack a positive cultural orientation towards overseas-born clinicians. While none of the informants suggested that some patients were racist, they acknowledged the additional challenges if cultural "comfort" was lacking. As with previous studies, the junior doctors reported problems with mediated communication (using an interpreter) and cultural differences in interacting about healthcare with clinicians (Malhotra et al., 2009), conceptualising mediated communication as a barrier rather than enabler of effective communication. The strategies that the junior doctors reported to overcome barriers had similarities with those reported by more experienced overseas-born doctors in a family practice setting (Jain & Krieger, 2011).

This study investigated intercultural communication in terms of both CALD patients and CALD doctors. The findings from this study setting, in which cultural diversity is commonplace, have implications for medical education and patient outcomes in similar settings. The perspectives of both junior doctors and senior clinicians provide more nuanced understandings of the challenges facing both doctors and patients. These insights could inform case studies written for raising awareness of intercultural communication in medical communication curricula. The junior doctors reported a range of strategies to overcome challenges; these strategies can also form the basis of discussion about their effectiveness and appropriateness. The uncertainty present throughout the junior doctors' narratives of care as well as the senior doctors' concerns about the junior doctors' skills in explaining complexity to patients underscores the need to include intercultural communication in the medical curriculum. It should be included not only in terms of cultural competence but in terms of awareness of how intercultural communication is enacted.

This study has some limitations. The fact that the junior doctor co-researchers conducted the focus groups interviews with the junior doctor participants, their peers, may have influenced the junior doctor participant responses. In addition, the study presents the findings of one population in a specific setting, and this may not

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necessarily be generalisable. Future studies should include patient perspectives as well as an ethnographic approach in order to provide greater insight into behaviours as they are enacted in intercultural communication.

We recommend that in health workforce migration destination countries, such as Australia, intercultural communication teaching refers not only to CALD patients but also makes reference to the cultural diversity of healthcare professionals. This study's findings suggest that overseas-born junior doctors may need better understanding of the lives of distinct populations, such as rural and indigenous peoples, in order to provide quality care. Medical educators should also acknowledge that some junior doctors have additional language skills that may be called upon in the care of CALD patients for whom they are not responsible. However, guidelines on ethical conduct about mediated communication by junior doctors should inform best practice. Furthermore, the junior doctors' comments on the constraints of providing effective health information to CALD patients reinforces the need to maintain and expand intercultural communication teaching so that health disparities for migrant groups can be addressed.

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References

Australian Government Department of Health. (2008). *Report on the audit of health workforce in rural and regional Australia*. Canberra, Australia: Author.

Australian Bureau of Statistics. (2011). *Census 2011 quickstats, Victoria*. Retrieved from http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/2?opendocument&navpos=220

Betancourt, J. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine*, *78*, 560–569.

Bollini, P., & Siem, H. (1995). No real progress towards equity: Health of migrants and ethnic-minorities on the eve of the year 2000. *Social Science & Medicine*, *41*(6), 819–828.

Cross, D., & Smallridge, A. (2011). Improving written and verbal communication skills for international medical graduates: A linguistic and medical approach. *Medical Teacher*, *33*, 64–67.

Dorgan, K., Lang, F., Floyd, M., & Kemp, E. (2009). International medical graduate–patient communication: A qualitative analysis of perceived barriers. *Academic Medicine*, *84*(11), 1567–1575.

Fiscella, K., & Frankel, R. (2000). Overcoming cultural barriers: International medical graduates in the United States. *Journal of the American Medical Association*, *283*(13), 1751.

Garling, P. (2008). *Acute care services in NSW public hospitals: Volume 3*. Final report of the Special Commission of Inquiry, Sydney, Australia. Retrieved from http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0020/34193/Volume_3_-_Special_Commission_Of_Inquiry_Into_Acute_Care_Services_In_New_South_Wales_Public_Hospitals.pdf

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Godkin, M., & Savageau, J. (2001). The effect of a global multiculturalism track on cultural competence of preclinical medical students. *Family Medicine*, *33*(3), 178–186.

Goulburn Valley Health. (2012). *Quality of care report 2011/2012*. Retrieved from http://www.gvhealth.org.au/AboutUsOurServices/AnnualQualityofCareReports.aspx

Hall, P., Keely, E., Dojeiji, S., Byszewski, A., & Marks, M. (2004). Communication skills, cultural challenges and individual support: Challenges of international medical graduates in a Canadian heathcare environment. *Medical Teacher*, *26*(2), 120–125.

Hawthorne, L. (2012). International medical migration: What is the future for Australia? *MJA Open*, *1*(Suppl. 3), 18–21.

Hawthorne, L., Minas, H., & Singh, B. (2004). A case study in the globalization of medical education: Assisting overseas-born students at the University of Melbourne. *Medical Teacher*, *26*, 150–159.

Henderson, S., Kendall, E., & See, L. (2011). The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: A systematic literature review. *Health & Social Care in the Community*, *19*(3), 225–249.

Jain, P., & Krieger, J. L. (2011). Moving beyond the language barrier: The communication strategies used by international medical graduates in intercultural medical encounters. *Patient Education and Counseling*, *84*(1), 98–104.

Kachur, E., & Altshuler, L. (2004). Cultural competence is everyone's responsibility. *Medical Teacher*, *26*, 101–105.

Kai, J., Bridgewater, R., & Spencer, J. (2001). "'Just think of TB and Asians', that's all I ever hear": Medical learners' views about training to work in an ethnically diverse society. *Medical Education*, *35*, 250–256.

Kai, J., Spencer, J., & Woodward, N. (2001). Wrestling with ethnic diversity: Toward empowering health educators. *Medical Education*, *35*, 262–271.

Kiessling, C., Dieterich, A., Fabry, G., Holzer, H., Langewitz, W., Muhlinghaus, I., & Schubert, S. (2010). Communication and social competencies in medical education in German-speaking countries: The Basel consensus statement. Results of a Delphi survey. *Patient Education and Counseling*, *81*(2), 259–266.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal*, *311*, 299–302.

Liddell, M., & Koritsas, S. (2004). Effect of medical students' ethnicity on their attitudes towards consultation skills and final year examination performance. *Medical Education*, *38*, 187–198.

Malhotra, A., Gregory, I., Darvill, E., Goble, E., Pryce-Roberts, A., Lundberg, K., & Hafstad, H. (2009). Mind the gap: Learners' perspectives on what they learn in communication compared to how they and others behave in the real world. *Patient Education and Counselling*, *76*, 385–390.

Mullan, F. (2005). The metrics of the physician brain drain. *New England Journal of Medicine*, *353*(17), 1810–1818.

National Health and Medical Research Council. (2005). *Cultural competency in health: A guide for policy, partnerships and participation*. Canberra, Australia: Author.

ISSN 1442-1100

Niu, N. N., Syed, Z., Krupat, E., Crutcher, B., Pelletier, S., & Shields, H. (2012). The impact of cross-cultural interactions on medical students' preparedness to care for diverse patients. *Academic Medicine*, *87*(11), 1530–1534.

Pasricha, A. (2012). Developing a measurement tool to assess medical students' cultural competency. *University of Ottawa Journal of Medicine*, *2*, 44–47.

Roberts, C. (2007). Intercultural communication in healthcare settings. In H. Kotthoff & H. Spencer-Oatey (Eds.), *Handbook of intercultural communication* (pp. 243–262). Berlin, Germany: Mouton de Gruyter.

Roberts, C., Sarangi, S., Southgate, L., Wakeford, R., & Wass, V. (2000). Oral examinations: Equal opportunities, ethnicity, and fairness in the MRCGP. *British Medical Journal*, *320*, 370–375.

Rosen, J., Spatz, E., Gaaserud, A., Abramovitch, H., Weinreb, B., Wenger, N., & Margolis, C. (2004). A new approach to developing cross-cultural communication skills. *Medical Teacher*, *26*(2), 126–132.

Skelton, J., Kai, J., & Loudon, R. (2001). Cross-cultural communication in medicine: Questions for educators. *Medical Education*, *35*, 257–261.

Tang, T. S., Fantone, J. C., Bozynski, M. E. A., & Adams, B. S. (2002). Implementation and evaluation of an undergraduate sociocultural medicine program. *Academic Medicine*, *77*, 578–585.

von Fragstein, M., Silverman, J., Cushing, A., Quilligan, S., Salisbury, H., & Wiskin, C. (2008). UK consensus statement on the content of communication curricula in undergraduate medical education. *Medical Education*, *42*, 1100–1107.

Woodward-Kron, R., Fraser, C., Pill, J., & Flynn, E. (2014). How we developed Doctors Speak Up: An evidence-based language and communication skills open access resource for international medical graduates. *Medical Teacher*, 37(1), 31–33. doi:10.3109/0142159X.2014.909584

Woodward-Kron, R., Hamilton, J., & Rischin, I. (2007). Managing cultural differences, diversity and the dodgy: Overseas-born students' perspectives of clinical education in Australia. *Focus on Health Professional Education*, *9*(3), 30–43.

Woodward-Kron, R., Hughson, J., Parker, A., Bresin, A., Hajek, J., Knoch, U., & Story, D. (2016). Culturally and linguistically diverse populations in medical research: Perceptions and experiences of older Italians, their families, ethics administrators and researchers. *Journal of Public Health Research*, *5*(667), 44–51.

Woodward-Kron, R., Stevens, M., & Flynn, E. (2011). The medical educator, the discourse analyst, and the phonetician: A collaborative feedback methodology for clinical communication. *Academic Medicine*, *85*(5), 565–570.

Yau, P., Woodward-Kron, R., Livesay, K., Elliott, K., & Nicholson, P. (2016). Cultural respect encompassing simulation training: Being heard about health through broadband. *Journal of Public Health Research*, *5*(657), 36–42.

Zulla, R., Baerlocher, M. O., & Verma, S. (2008). International medical graduates (IMGs) needs assessment study: Comparison between current IMG trainees and program directors. *BMC Medical Education*, *8*(42), 5.

ISSN 1442-1100