

Intercultural communication

Culture: What is it?

Bates and Flog (1990: 466): 'Culture is a system of shared beliefs, values, customs, behaviours, and artefacts that members of a society use to cope with one another and with their world, and that are transmitted from generation to generation'.

In what way does culture influence the person's psychosocial functioning? Droždek (2007: 7) says that 'culture impacts the regulation and expression of emotions, sets limits of tolerance of specific and strong emotions, and provides lay theories and strategies about handling emotions'.

Furthermore Lewis and Ippen (2004: 13) say that culture provides the '... psychic structure for relationships among members of a social group while simultaneously helping them to make meaning of the physical world'.

Thinking about cultural differences

A classic formulation of the dimensions on which cultures differ was provided by Geert Hofstede (1980) in his study of study of work values. He identified five dimensions of national cultures: 1) individualism, 2) power distance, 3) uncertainty avoidance, 4) masculinity (task orientation) and 5) long-term orientation.

Hofstede's framework still serves as a benchmark for discussion of cultural dimensions and is "the dominant culture paradigm in business studies" (Nakata, 2009: 3).

Individualism - collectivism

Individualistic cultures "offer their members a great deal of freedom, the belief being that this freedom makes it possible for each person to achieve personal success" (Adler & Elmhorst, 2008, p. 48). Members tend to "put their own interests and those of their immediate family ahead of social concerns" (p. 48).

Or as Triandis puts it, individualism is:

'a social pattern that consists of loosely linked individuals who view themselves as independent of collectives; are primarily motivated by their own preferences, needs, rights, and the contracts they have established with others; give priority to their personal goals over the goals of others; and emphasize rational analyses of the advantages and disadvantages to associating with others' (Triandis, 1995: 2).

In contrast, members of collectivist cultures "have tight social frameworks in which members of a group . . . feel primary loyalty toward one another and the group to which they belong" (p. 48). Triandis says: collectivism is:

'a social pattern consisting of closely linked individuals who see themselves as parts of one or more collectives (family, co-workers, tribe, nation); are primarily motivated by the norms of, and duties imposed by, those collectives; are willing to give priority to the goals of these collectives over their own personal goals; and emphasize their connectedness to members of these collectives' (Triandis, 1995: 2).

Power Distance

Cultures with low power distance "downplay differences in power" (Adler & Elmhorst, 2008, p. 50) and its members are comfortable approaching or challenging superiors. Cultures with high power distance accept an unequal distribution of power and the fact that "some members have greater resources and influence than others" (p. 50).

Task Orientation

Task-oriented cultures focus on making its members "more competent through training and use of up-to-date methods and are highly concerned with individual success" (Adler & Elmhorst, 2008: 51). Cultures with high social orientation "focus

more on collective concerns” such as cooperative problem solving and maintaining a friendly atmosphere (p. 51).

Uncertainty Tolerance

Cultures that tolerate uncertainty are more comfortable with unpredictability and risk taking, and they are “relatively tolerant of behaviour that differs from the norm” (Adler & Elmhorst, 2008, p. 50). Cultures that avoid uncertainty “are less comfortable with change. They value tradition and formal rules, and show less tolerance for different ideas” (p. 50).

Long term orientation

‘Long Term Orientation stands for the fostering of virtues oriented towards future rewards, in particular perseverance and thrift. Its opposite pole, Short Term Orientation, stands for the fostering of virtues related to the past and present, in particular, respect for tradition, preservation of ‘face’ and fulfilling social obligations’ (Hofstede, 2001: 359).

Nakata (2009) believes the situation is now more complex:

‘When Hofstede wrote his book in 1980, the world was a simpler place’ (p. 5). Now with the advent of globalization, “cultures are traversing national borders, co-mingling, hybridizing, morphing, and clashing through media, migration, telecommunications, international trade, information technology, supranational organizations, and unfortunately terrorism’ (Nakata, 2009: 4).

Edward Hall’s (1976) notion of high and low context cultures

A low-context culture ‘uses language primarily to express thoughts, feelings, and ideas as clearly and logically as possible . . . The meaning of a statement is in the words spoken’ (Adler & Elmhorst, 2008: 47).

Low-context communication occurs predominantly through *explicit* statements in text and speech – the mass of the information is vested in the explicit code. As such, most of the information must be in the transmitted message in order to make up for what is missing in the context. Cultures, such as Scandinavians, Germans, and the Swiss, are predominantly low-context communicators (Wurtz, 2005).

A high-context culture, on the other hand, “relies heavily on subtle, often nonverbal cues to convey meaning, save face, and maintain social harmony. Communicators . . . discover meaning from the context in which a message is delivered” (p. 47).

In high context cultural settings we may find people *implying* a message through elements which is not spoken explicitly; these may include other communication cues such as body language, eye movement, para-verbal cues, and the use of silence (Wurtz, 2005). These *transactions* feature pre-programmed information that is in the receiver and in the setting, with only minimal information in the transmitted message (Hall, 1976 as presented in Dahl, 2006). Cultures considered high-context are Japan and Arab countries.

Hall proposes that ‘meaning and context are inextricably bound up with each other’ (Hall, 2000: 36). He further suggests that in order to understand communication, we must look at the meaning and context together *with* the code (words). Furthermore, context may refer to the situation, background, or environment connected to the event, situation, or individual (Wurtz, 2005).

Migration

An estimated 214 million people -3.1 per cent of the world's population—have left their homes in poorer countries for richer ones in search of a better life (International Organization for Migration 2010). Precise numbers are difficult to establish, but somewhere between 20 and 30 million people have migrated in search of work on an unauthorized, or “illegal,” basis. (Willen et al 2011)

According to the International Organization for Migration (IOM) (2009), more than 200 million people are estimated to be international migrants; another 26 million are internally displaced in at least 52 countries as a result of conflict. Overall migrants comprise 3% of the world's population (IOM 2009).

'The migrant has left his original place, where he built the first and fundamental cultural and psychological identifications, moving to another place, in search of a better life. As a consequence, he or she can suffer the loss of the primordial world of his existence, to face a long, and frequently difficult process of acculturation to the new culture. Thus migration can be seen as a courageous and complex act, which affects the person's life, bringing many changes in the family history and in the individual cultural identity' (Wiese, 2010: 142-143)

Mobility and population migration are important human processes affecting a broad range of social outcomes. The 2009 World Development Report, for instance, explores the positive development impact of population mobility resulting from both remittance flows and the concentration of skills in geographical areas with the greatest economic potential (Mendola 2006; Skeldon 2008; World Bank 2008; Chappell & Glennie 2009).

Health and migration

Five of ten of the leading causes of burden of disease in developing countries in 2004 were communicable diseases, including HIV / AIDS (5.2%), malaria (4.0%) and tuberculosis (TB) (2.7%) (WHO 2008). Ranked sixth among the ten leading causes of Disability-Adjusted Life-Years is the aggregated measure of 11 of the so-called neglected tropical diseases (NTDs) (WHO 2006; Hotez et al. 2007).

Health care workers are among the professionals most affected by global migration movements. Through various channels, health professionals – especially nurses – move in droves from developing countries to developed countries: from the Philippines to Saudi Arabia, from India to Ireland, and from Zimbabwe to the United Kingdom, (Kaelin, 2011: 30).

There is increasing demand for health-care workers – especially in OECD countries – as a result of rising incomes, new medical technology, increased specialization of health services and population ageing (OECD/WHO, 2010).

The nurse population ratio in Europe is ten times higher than in Africa or South-East Asia; it is likewise ten times higher in North America than in South America (Kingma, 2006; Kline, 2003). Migration further aggravates this inequality by withdrawing nurses from poor countries for the supply of the rich ones. Choy (2003: 3) describes this cluster of nurses in affluent countries as the 'Empire of Care'.

Many governments across the Caribbean, Africa, Asia and the Middle East are responding to the global nurse shortage by “producing nurses for export” (Buchan et al, 2005; Hosein and Thomas, 2007; Thomas et al, 2005; Yeates, 2009).

'the most common unit of analysis referred to in public health, the nation–state, is not all that meaningful to organisms such as dengue virus, *Vibrio cholera* O, HIV, penicillinase-producing *Neisseria gonorrhoeae*, multidrug-resistant tuberculosis, and hepatitis B virus. Such organisms proudly disregard political boundaries' (Farmer 2010: 158–159)

Migrants are portrayed as both overly demanding and undeserving of health services, and they have become scapegoats for a system in decline (Goldade, 2009).

In Germany, for example, the country's commitment to universal coverage stands in tension with its strict policy environment. As a result, unauthorized im/migrants remain highly conspicuous when they seek health services, and they are the targets of increased scrutiny. Until recently, providing medical aid to unauthorized persons could potentially be interpreted as a criminal act, and current legal structures continue to create ambiguous situations for health care providers and unauthorized im/migrants who are sick or injured (Castaneda 2009).

Health Tourism

Increasing numbers of individuals are leaving their local communities and crossing national borders in search of affordable, timely medical care (Connell, 2006; Ramirez de Arellano, 2007). Such countries as India, Malaysia, Singapore, Thailand and the Philippines are common destinations in Asia (Whittaker, 2008; Henderson, 2003). In North America, many citizens of the USA and, to a lesser extent, holidaying 'snowbirds' from Canada, arrange care in Mexican hospitals and clinics located along the Mexico–US border (Judkins, 2007; Cuddehe, 2009).

The practice of medical tourism is not new; people have travelled abroad for treatment for centuries. There are several reasons why people do this: some cannot afford healthcare in their home countries (Burkett, 2007; Dunn, 2007; Milstein & Smith, 2006), others cannot afford to wait for their national system to provide treatment (Ramirez de Arellano, 2007; Turner, 2007; Muzaffar & Hussein, 2007); some treatments are not available in all countries (Turner, 2007; Muzaffar & Hussein, 2007; Connell, 2008); or those who have taken part in a Diaspora may prefer treatment at 'home'(Reed, 2008; UNCTAD-WHO, 1998).

Interesting conditions from around the world

Albasmasi

"In the forty days after childbirth known as the *lohusa* period, a woman is liable to contract *albasmasi*. This condition, characterised by the woman seeing everything in red, turning hot and getting cramps as well as choking, is one of the most feared reactions connected with childbirth. All women have heard of it and been in touch with it one way or another in Kulu. *Albasmasi* is an illness with specific symptoms. When a case has been established, it is only the personal and folk sectors of health care that can provide treatment. A scientific doctor will not be consulted. The Kulu women know that only their own experts can cure a person from *albasmasi* and that scientific doctors have not even heard of the illness" (Sachs 1983, p. 86).

Mexico:

The way people described the experience of health and illness in a Mexican community studied by Castro (1995) was intimately bound up with their social circumstances. To the

impoverished inhabitants of Ocuituco, the terms used to describe illness and wellness relate to material circumstances. To be healthy is to be *gordo*, which means fat, fleshy or stout. To be ill is to be *flaco*, which means thin. Health, then, is conceptualised as fat, with the implication that one is having enough to eat.

Sicilian-Canadians:

Migliore (1993) describes the way Sicilian-Canadians use the idea of *nerves* to 'express feelings of concern and distress over their social situation. They translate social problems into the metaphorical language of psychic and somatic distress' (p.343). 'Nerves' operates as an illness category and as a device for metaphorically expressing a variety of personal and social problems.

'individuals can signal discomfort through verbal cues such as *nierbi gravaccati* [entangled nerves], *nierbi agruppati* [knotted nerves], and *spilatura* [perforated nerves]. These statements conjure up images of pain, disorder, and impairment of function. In the case of *nirbusu*, the metaphorical representations convey a very different message. Here, people rely on the language of distress to communicate that they are experiencing psychic and somatic effects because they are no longer in control of their emotions. Metaphorical statements that convey this message include *li nierbi mi sbattinu* [the nerves are shaking me], *triemu comu un busciarieddu* [I'm trembling like a stalk of wheat], *mi stannu scutiennu li nierbi* [my nerves are starting to get excited, to shake], and *mi stannu acchianannu li nierbi*' (Migliore, 1993: 347)

Depression why does it vary?

Nationality can affect the likelihood of depression. In a cross national study by Bromet et al (2011) lifetime rates of major depressive episode ranged from 21% (France) and 19% (US) to 6.6% (Japan) and 6.5% (China).

A good deal of research on depression (and other problems) is conducted from a European or American point of view, such that many researchers tend to see other cultures' problems as masked versions of their own (Patel and Winston, 1994). For example Ndeti and Muhangi (1979) reported that anxiety and depression were the commonest problems at a rural clinic in Kenya. Yet they say that 'none of the patients complained of subjective symptoms of either apprehension or fearfulness in the case of anxiety' (p.270). Likewise, there was a lack of 'sadness, guilt or nihilism in the case of depression' (p.270). Even 'direct enquiry about these feeling states also failed to elicit positive responses' (p.270). It would appear that the power of the language of Western diagnostic systems enabled even the absence of key features of anxiety and depression to be glossed over or ignored in the eagerness to find a diagnosis.

Some further evidence about the prevalence of depression comes from Kleinman, (1988) who claimed that depression was rare in India, Africa and other non western cultures. Kleinman believes that depression rates are elevated in response to the pressures of modernisation and industrialisation. In Taiwan, claims Kleinman, in two studies by Lin et al done 15 years apart in the late 1940s and the 1960s a significant increase in depression and anxiety disorders was noted. In China, says Kleinman, most of the research done from the 1950s onwards does not detect depression until after about 1980.

Some authors argue that people express their distress through more somatic symptoms in non-western countries, for example by sleep disturbance, feelings of fatigue, weakness and weight loss (Manson & Good, 1993; Marsella, 1980)

Fenton and Sadiq-Sangster (1996) note that although there is no Punjabi phrase which directly translates directly as 'depression', some symptom descriptions 'must sound familiar to Western Psychiatrists' (Krause, 1989:567).

For example:

"My heart kept falling and falling . . . I felt as if my head was about to burst. The life would go out of my heart."

"My heart has taken many shocks."

"I'd get up in the morning and feel as if something heavy was resting on my heart."

(Fenton and Sadiq-Sangster, 1996: 75)

A woman whose nephew had died in an accident told Fenton and Sadiq-Sangster "My heart is weak. I am ill with too much thinking . . . the blood becomes weaker with worry . . . I have the illness of sorrows (*duk bemaari*)."

(Fenton and Sadiq-Sangster, 1996: 75)

Or, as another participants told the authors

'I feel eaten away with hurt and sorrow . . . there are hundreds of worries and I just keep thinking about them in my heart. I was very bad . . . even now there is little difference. These worries are still here. What do I do? What is the medicine for them? I saw the doctor. I just told him about how I wasn't sleeping well . . . and the pain in my arm. The doctor gave me pain-killers and cream to rub in my arms. But there is no tablet for my sorrow (*ghumgeen*) is there? This sorrow will be with me for ever.

(Fenton and Sadiq-Sangster, 1996: 79)

Fenton and Sadiq-Sangster talk about what they call 'thinking-in-the-heart-illness' which their participants described, which denotes a 'state of mind, of heart, of the emotions, which takes shape as a culturally defined illness' (p. 81).

World views

'We must be able to recognize that we operate from within a world view and simultaneously be able to be free of our worldview so that we might be able to understand and appreciate the meaning of another's world view perspective . . . Trying to replace another's reality with our own is a good working definition of oppression. If we are to be oppression sensitive we must work from *within* the person's experience . . . the critical component in effective cross-cultural work is developing a working knowledge of our own worldview, including the biases we bring to our work with others. Only then will compassionate healing be possible'

(Rodriguez, 1999: 7).

Skills, ideas and concepts that might assist transnational communication

Koehn (2004) provides a useful taxonomy which includes:

1. Analytic Skills

Research on patient-provider communication and on cultural competence in clinical consultations suggests that the extent to which participants possess transnational analytic skills in the migrant-health-care context can be investigated fruitfully by focusing on five discriminating analytic abilities (see Johnson et al., 2001; Kim, 2001). These analytic skills, which draw upon what might be considered "critical epidemiology" (see Farmer, 1999, p 5) and efforts to incorporate the perspectives and experiences of persons "at greatest risk for loss of voice" (Roter et al., 2001: 81), involve clinician/patient understanding of:

- The conditions that led the migrant patient to leave his/her homeland (migrants understand why they left the homeland. For them, the parallel analytic challenge involves grasping the conditions that affect life in the host society);
- The health-care conditions that the migrant faces in the host society;
- The beliefs and practices of the migrant's culture and of the clinician's biomedical framework regarding the causes, treatment, and prevention of illness (Kleinman et al., 1978; Ma, 1999);
- The other's personal beliefs and practices regarding the causes, treatment, and prevention of illness (Pachter, 2000; Elderkin-Thompson et al., 2001; Perry, 2001); and
- Connections between the migrant's life circumstances and his/her (family's) current health-care needs.

2. Emotional Skills

The extent to which migrants, physicians, and supporting health-care professionals possess the most relevant transnational emotional skills can be assessed intersubjectively with reference to six basic items. These are:

- Openness to respecting the patient's/provider's health-related beliefs, practices, and agenda (see DiMatteo, 1997; Kline and Huff, 1999);
- Valuing and reinforcing the other's ability/contributions to overcome challenges faced as a migrant or in helping migrants (see Smith, 1996; Kline and Huff, 1999);
- Having an optimistic outlook on prospects that the care provider can make a difference in meeting the migrant's health-care needs (Novack, 1995; Stewart et al., 1999);
- Acknowledging and validating the other's beliefs and practices (Western biomedical, ethnocultural, or nonstandard) regarding the causes, treatment, and prevention of illness even if one does not agree with them (Pachter, 2000; Oster et al., 2000; Johnson et al., 1995; Lazare et al., 1995; Smith, 1996; Barry et al., 2001; Stewart et al., 1999; AMA, 1999; Coulehan and Block, 1997);
- Being personally interested in and concerned about the migrant's health (Roter and Hall, 1992; Stewart et al., 1999); and
- Openness to being accepted in the other's (migrant or host) culture (Kim, 2001; Andrews, 1999; St. Clair and McKenry, 1999).

3. Creative/Imaginative Skills

Creative/imaginative skills can be assessed in the migrant health-care context in terms of five items. First, does the migrant contribute ideas about his/her own health care and does the healer help establish and reinforce an atmosphere that is conducive to the contribution of problem-solving ideas (see Roter et al., 2001; Roter and Hall, 1992; Miller, 2001)? Second, are the participants able to apply the deciphered physical and emotional experiences of the migrant in addressing his/her current illness/health needs? Third, does the care provider suggest, and does the patient utilize, complementary combinations of Western medicine and the traditional health-care beliefs and practices of his/her culture (Pachter, 2000; Stewart et al., 1999)? Skaer et al., (1996: 33) suggest that "health care practitioners need to make a standard practice of asking their patients about their use of folk remedies and/or nontraditional providers," while the AMA's Guide to Talking to Your Doctor recommends, "always tell your doctor about any alternative therapy you are using" (Perry, 2001, pp 99–100). Fourth, are participants able to recommend health-care practices or coping strategies that are suitable for the conditions that migrants similarly situated in the host society face (Hassinen-Ali-Azzani, 2002)? Fifth, does the

migrant suggest ideas about his/her health-care goals/treatment and does the clinician include such suggestions in his/her recommendations (Street, 1991; Lecca et al., 1998)?

4. Communicative Skills

Seven items guide operationalization of communicative skills in the analysis of migrant–physician-support professional interactions. They are:

- Ability to communicate in the other's first language (or in a mutually understood third language such as English) concerning health conditions and treatment (Flores, 2000);
- Ability to communicate with the patient/clinician through an interpreter when necessary (Ferguson and Candib, 2002);
- Use of culturally appropriate non-verbal communication (such as interview pace and gestures);
- The ability to express (encourage expression of) health-related worries and questions (Lazare et al., 1995; Dye and DiMatteo, 1995; Roter and Hall, 1992; Street, 1991; Putnam and Lipkin, 1995);
- The ability to listen attentively to the other in a genuine effort to comprehend and to take seriously what s/he is saying (Novack, 1995; Stewart et al., 1999; Morales et al., 1999; Cassell, 1985; Roter and Hall, 1992; Harwood, 1981; Saha et al., 1999);
- The ability to express (encourage expression of) uncertainties, doubts, and disagreements (Dye and DiMatteo, 1995; Waitzkin, 1991; Dressler and Oths, 1997; Street, 1991); and
- The ability to convey health/illness information (or health-care instructions) and to answer/raise questions in a way that the other can understand fully (Morales et al., 1999; Roter and Hall, 1992; Harwood, 1981; Perry, 2001; Saha et al., 1999; David and Rhee, 1998; Stewart et al., 1999; Putnam and Lipkin, 1995).

5. Functional Skills

Functional skills can be assessed in the migrant-health-care context with reference to 10 items. These items are:

- Showing that one cares about the other individual's personal situation and troubles (Novack, 1995; Harwood, 1981; Stewart et al., 1999; Flores, 2000);
- Not treating the patient/clinician in a way that makes him/her upset (Roter and Hall, 1992; Stewart et al., 1999);
- Relating to the patient/provider in a way that builds mutual trust (see Pachter, 2000; Oster et al., 2000; Watters, 2001; Mollica et al., 1987; Mechanic, 1996);
- Joint participation (involving the migrant) in making health/illness assessments (Lazare et al., 1995; Dye and DiMatteo, 1995; Roter and Hall, 1992; Stewart et al., 1999);
- Offering (suggesting ways to make) health-care instructions that are easy to adhere to (Dye and DiMatteo, 1995);
- Taking into consideration the influence of family and/or community members on the patient's illness/health situation (Lazare et al., 1995; Roter and Hall, 1992; Harwood, 1981);
- Requesting/giving (and explaining expected risks and benefits associated with) alternatives and choices before decisions are reached regarding health-care measures (Roter et al., 2001; Deber et al., 1996; Cassell, 1985; Golin et al., 2002; Braddock et al., 1999; Cooper-Patrick et al., 1999);
- Making an effort(s) to activate societal resources that are likely to enhance the migrant's health situation; and
- Perceived likelihood that the clinician would provide health care effectively in the migrant's homeland or that the migrant will exercise responsibility for

thoughtful and effective health behavior in the receiving land (Roter et al., 2001; Kaplan et al., 1995).

References

- Adler, R. B., & Elmhorst, J. M. (2008). *Communicating at work: Principles and practices for business and the professions* (9th ed.). Tuas Basin Link, Singapore: McGraw-Hill.
- American Medical Association (AMA) (1999) Cultural Competence Compendium, Chicago: AMA.
- Andrews MM (1999) Theoretical foundations of transcultural nursing. In: *Transcultural Concepts in Nursing Care*, Andrews MM, Boyle JS (editors). 3rd ed. Philadelphia: Lippincott, pp 3–22
- Barry CA, Stevenson FA, Britten N, Barber N, Bradley CP (2001) Giving voice to the lifeworld: more humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. *Social Science and Medicine* 53: 487–505.
- Bates, D. G., & Flog, F. (1990). *Cultural anthropology* (3rd ed.). New York: McGraw-Hill.
- Braddock CH, Edwards KA, Hasenberg NM, Laidley TL, Levinson W (1999) Informed decision making in outpatient practice: time to get back to basics. *JAMA* 282: 2313–2320
- Briam, C. (2010) 'Outsourced': Using a comedy film to teach intercultural communication. *Business Communication Quarterly*, 73 (4): 383-398.
- Bromet, E., Andrade, L.H., Hwang, I., Sampson, N.A., Alonso, J., de Girolamo, G., de Graaf, R., Demyttenaere, K., Hu, C., Iwata, N., Karam, A.N., Kaur, J., Kostyuchenko, S., Lépine, J.P., Levinson, D., Matschinger, H., Mora, M.E.M., Browne, M.O., Posada-Villa, J., Viana, M.C., Williams, D.R., Kessler, R.C. (2011) Cross-national epidemiology of DSM-IV major depressive episode, *BMC Medicine*, 9 (90). <http://www.biomedcentral.com/1741-7015/9/90>
- Buchan, J., Kingma, M. & Lorenzo, Fely, M. (2005). *International migration of nurses: Trends and policy implications*. The Global Nursing Review Initiative, Issue Paper 5. Geneva, International Council of Nurses.
- Burkett, L. (2007). Medical tourism. Concerns, benefits, and the American legal perspective. *Journal of Legal Medicine*, 28, (2): 223–45.
- Cassell EJ (1985) *Talking with Patients, Vol 1: The Theory of Doctor-patient Communication*, Cambridge, MA: MIT Press
- Castaneda, H. (2009) Illegality as Risk Factor: A Survey of Unauthorized Migrant Patients in a Berlin Clinic. *Social Science and Medicine*, 68, (8): 1–9.
- Castro, R. (1995) The subjective experience of health and illness in Ocuituco: A case study, *Social Science and Medicine*, 41, (7) 1005-1021.
- Chappell L & Glennie A (2009) Maximising the development outcomes of migration: a policy perspective, Global Development Network and Institute for Public Policy Research
- Choy, C.C. (2003). *Empire of Care. Nursing and Migration in Filipino American History*. Durham & London: Duke University Press.
- Connell J. (2006) Medical tourism: sea, sun, sand and . . . surgery. *Tourism Management*, 27:1093–1100.
- Connell, J. (2008) Tummy tucks and the Taj Mahal? Medical tourism and the globalization of health care. In: Woodside, A.G. & Martin, D. (Eds.). *Tourism Management*. Waikato, NZ: CAB International (ps. 232–44).

Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, et al. (1999) Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association* 282:583–589.

Coulehan JL, Block MR (1997) *The Medical Interview: Mastering Skills for Clinical Practice*, 3rd ed. Philadelphia: FA Davis

Cuddehe M. (2009) Patients without borders: the rise of Mexican medical tourism. *New Republic*, 17: 16–17.

David RA, Rhee M (1998) The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mount Sinai Journal of Medicine*, 65: 393–397.

Deber R, Kraetschmer N, Irvine J (1996) What role do patients wish to play in treatment decision making? *Archives of Internal Medicine* 156:1414–1420

DiMatteo MR (1997) Health behaviors and care decisions. In: *Handbook of Health Behavior Research II: Provider Determinants*, Gochman DS (editor). New York: Plenum Press, pp 5–22.

Dressler WW, Oths KS (1997) Cultural determinants of health behavior. In: *Handbook of Health Behavior Research I: Personal and Social Determinants*, Gochman DS (editor). New York: Plenum Press, pp 359–378

Droždek, B. (2007). The rebirth of contextual thinking in psychotraumatology. In J. P. Wilson & B. Droždek (Eds.), *Voices of trauma: Treating survivors across cultures* (pp. 1-25). New York: Brunner-Routledge.

Dunn, P. (2007) Medical tourism takes fight. *Hospitals and Health Networks* 2007;81(11):40–2, 44.

Dye NE, DiMatteo MR (1995) Enhancing cooperation with the medical regimen. In: *The Medical Interview: Clinical Care, Education, and Research*, Lipkin M Jr, Putnam SM, Lazare A (editors). New York: Springer, pp 134–144.

Elderkin-Thompson V, Silver RC, Waitzkin H (2001) When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Social Science and Medicine* 52:1343–1358.

Farmer P (1999) *Infections and Inequalities: The Modern Plagues*, Berkeley, CA: University of California Press.

Farmer, P. (2010) Rethinking “Emerging Infectious Diseases.” In Farmer, P., Saussy, H. & Kidder, T. (Eds.) *Partner to the Poor: A Paul Farmer Reader*. (ps. 155–173) Berkeley: University of California Press

Fenton, S. & Sadiq-Sangster, A., (1996) Culture, relativism, and the expression of mental distress: South Asian women in Britain, *Sociology of Health and Illness*, 18, (1): 66-85.

Ferguson WJ, Candib LM (2002) Culture, language, and the doctor-patient relationship. *Family Medicine* 34:353–361.

Flores G (2000) Culture and the patient-physician relationship: achieving cultural competency in health care. *Journal of Pediatrics* 136:14–23

Goldade, K. 2009 “Health Is Hard Here” or “Health for All”? The Politics of Blame, Gender, and Health Care for Undocumented Nicaraguan Migrants in Costa Rica. *Medical Anthropology Quarterly*, 23, (4): 483–503.

Golin C, DiMatteo MR, Duan N, Leake B, Gelberg L (2002) Impoverished diabetic patients whose doctors facilitate their participation in medical decision making are more satisfied with their care. *Journal of General Internal Medicine* 17:857–866.

Hall, E. T. (1976). *Beyond Culture*. New York: Doubleday.

Hall, E. T. (2000). Context and meaning. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural Communication: A Reader*, 9th ed. (pp. 34-43). Belmont, CA: Wadsworth Publishing Co.

Harwood A (1981) Guidelines for culturally appropriate health care. In: *Ethnicity and Medical Care*, Harwood A (editor). Cambridge, MA: Harvard University Press, pp 482–507

- Hassinen-Ali-Azzani T (2002) Health and Children Are the Gifts of God: An Ethnographic Study of Health Concepts and Family Life Processes among Somalis during the Period of Cultural Transition in Finland, Kuopio, Finland: Kuopio University Publications, Social Sciences, p 95.
- Henderson J. (2003) Healthcare tourism in Southeast Asia. *Tourism Review International*, 7: 111–121.
- Hofstede (2001), *Culture's Consequences*, 2nd ed Thousand Oaks, CA: Sage Publications.
- Hotez, P.J., Molyneux, D. & Fenwick, A. (2007) Control of neglected tropical diseases. *New England Journal of Medicine*, 357: 1018–1027.
- Hosein, R. & Thomas, C. (2007). Caribbean Single Market Economy (CSME) and the intra-regional migration of nurses: Some proposed opportunities, *Global Social Policy*, 7, (3): 316–338.
- Hu, Y. & Fan, W. (2011) An exploratory study on intercultural communication research contents and methods: A survey based on the international and domestic journal papers published from 2001 to 2005 *International Journal of Intercultural Relations*, 35: 554-566.
- International Organization for Migration (2010) Global Estimates and Trends. <http://www.iom.int/jahia/Jahia/about-migration/facts-and-figures/global-estimates-and-trends>, accessed July 3, 2011.
- Jackson, J. (2011) Cultivating cosmopolitan, intercultural citizenship through critical reflection and international, experiential learning, *Language and Intercultural Communication*, 11 (2): 80-96.
- Johnson TM, Hardt EJ, Kleinman A (1995) Cultural factors in the medical interview. In: *The Medical Interview: Clinical Care, Education, and Research*, Lipkin M Jr, Putnam SM, Lazare A (editors). New York: Springer, pp 153–162.
- Judkins, G. (2007) Persistence of the U.S.-Mexico border: expansion of medical tourism and trade liberalization. *Journal of Latin American Geography*, 6: 11–32.
- Kaelin, L. (2011) A question of justice: Assessing nurse migration from a philosophical perspective, *Developing World Bioethics*, 11, (1): 30-39.
- Kaplan SH, Gandek B, Greenfield S, Rogers W, Ware JE (1995) Patient and visit characteristics related to physicians' participatory decision-making style: results from the medical outcomes study. *Medical Care* 33:1176–1187
- Kiata, L. & Kerse, N. (2004) Intercultural residential care in New Zealand, *Qualitative Health Research*, 14, (3): 313-327.
- Kim YY (2001) *Becoming Intercultural: an Integrative Theory of Communication and Cross-cultural Adaptation*, Thousand Oaks, CA: Sage Publications.
- Kingma, M. (2006) *Nurses on the Move. Migration and the Global Health Care Economy*. Ithaca, NY: Cornell University Press:
- Koehn, P.H. (2004) Global Politics and Multinational Health-care Encounters: Assessing the Role of Transnational Competence *Eco Health*, 1: 69-85.
- Kleinman, A. (1988) *Rethinking psychiatry*, New York: The Free Press.
- Kleinman A, Eisenberg L, Good B (1978) Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine* 88:251–258.
- Kline, D.S. (2003) Push and Pull Factors in International Nurse Migration. *Journal of Nursing Scholarship*, 35: 107–111.
- Kline MV, Huff RM (1999) Moving into the 21st century: final thoughts about multicultural health promotion and disease prevention. In: *Promoting Health in Multicultural Populations: a Handbook for Practitioners*, Huff RM, Kline MV (editors). Thousand Oaks, CA: Sage Publications, pp 501–516
- Krause, I.B. (1989) Sinking heart: a Punjabi communication of distress. *Social Science and Medicine*, 29(4), 563-7.

- Lazare A, Putnam SM, Lipkin M Jr (1995) Three functions of the medical interview. In: *The Medical Interview: Clinical Care, Education, and Research*, Lipkin M Jr, Putnam SM, Lazare A (editors). New York: Springer, pp 3–19.
- Lecca PJ, Quervalu I, Nunes JV, Gonzales HF (1998) *Cultural Competency in Health Social and Human Services*, New York: Garland.
- Lewis, M. L., & Ippen, C. G. (2004). Rainbows of tears, souls full of hope: Cultural issues related to young children and trauma. In J. D. Osofsky (Ed.), *Young children and trauma: Intervention and treatment* (pp. 11-46). New York: Guilford.
- Ma GX (1999) Between two worlds: the use of traditional and Western health services by Chinese immigrants. *Journal of Community Health* 24:421–437
- Manson, S.M. & Good, B.J. (1993) Cultural considerations in the diagnosis of DSM IV mood disorders: Cultural proposals and supporting papers for DSM IV, Submitted to the DSM Task Force by the Steering Committee, NIMH-Sponsored Group on culture and diagnosis.
- Marsella, A.J. (1980) Depressive experience and disorder across cultures, In Triandis, H.C. & Draguns, J. (Eds.) *Handbook of cross cultural psychology*, volume 6, Boston: Allyn & Bacon.
- Mechanic D (1996) Changing medical organization and the erosion of trust. *Milbank Quarterly* 74:171–189.
- Mendola M (2006) Rural out-migration and economic development at origin: what do we know? Sussex Migration Working Paper No. 40, Sussex centre for Migration Research.
- Migliore, S. (1993) 'Nerves': The role of metaphor in the cultural framing of experience. *Journal of Contemporary Ethnography*, 22, (3): 331-360.
- Miller, EA (2001) "Telemedicine and doctor-patient communication: an analytical survey of the literature" *Journal of Telemedicine and Telecare* 7: 1–17.
- Milstein A, Smith M. America's new refugees – seeking affordable surgery offshore. *New England Journal of Medicine*, 355, (16): 1637–40.
- Mollica R, Wyshak G, Lavelle J (1987) The psychosocial impact of war trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry* 144:1567–1572.
- Morales LS, Cunningham WE, Brown JA, Liu H, Hays RD (1999) Are Latinos less satisfied with communication by health care providers? *Journal of General Internal Medicine* 14: 409–417
- Muzaffar, F. & Hussain, I. (2007) Medical tourism: are we ready to take the challenge? *Journal of Pakistan Association of Dermatologists*, 17: 215–8.
- Nakata, C. (Ed.). (2009). *Beyond Hofstede: Culture frameworks for global marketing and management*. London, England: Palgrave Macmillan.
- Ndetei, D.M. & Muhangi, J., (1979) The prevalence and clinical presentation of psychiatric illness in a rural setting in Kenya, *British Journal of Psychiatry*, 135, 269-272.
- Novack DH (1995) Therapeutic aspects of the clinical encounter. In: *The Medical Interview: Clinical Care, Education, and Research*, Lipkin M Jr, Putnam SM, Lazare A (editors). New York: Springer, pp 32–49
- Oster N, Thomas L, Joseff D (2000) *Making Informed Medical Decisions: Where to Look and How to Use What You Find*, Beijing: O'Reilly
- Pachter LM (2000) Working with patients' health beliefs and behaviours: the awareness-assessment-negotiation model in clinical care. In: *Child Health in the Multicultural Environment. Report of the 31st Ross Roundtable on Critical Approaches to Common Pediatric Problems*, Silverman E (editor). Columbus, OH: Ross Products Division, Abbott Laboratories, pp 36–43
- Patel, V. & Winston, M., (1994) 'Universality of mental illness' revisited: Assumptions, artefacts and new directions, *British Journal of Psychiatry*, 165, 437-440.
- Perry A (editor). (2001) *The American Medical Association's Guide to Talking to Your Doctor*, New York: John Wiley & Sons.

- Putnam SM, Lipkin M Jr (1995) The patient-centered interview: research support. In: *The Medical Interview: Clinical Care, Education, and Research*, Lipkin M Jr, Putnam SM, Lazare A (editors). New York: Springer.
- Ramirez de Arellano A. (2007) Patients without borders: the emergence of medical tourism. *International Journal of Health Services*, 37: 193–198.
- Reed, C.M. (2008) Medical tourism. *Medical Clinics of North America*, 92, (6): 1433–46.
- Rodriguez, E. (1999) The heart of the matter: Worldview as a central concept in effective cross-cultural work. *The Journal of the California Alliance for the Mentally Ill*. 10 (1), 5-7.
- Roter DL, Hall JA (1992) *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*, Westport, CT: Auburn House
- Roter D, Stashefsky M, Rudd R (2001) Current perspectives on patient education in the US. *Patient Education and Counseling* 44: 79–86.
- Sachs, L. (1983) *Evil Eye or Bacteria: Turkish migrant women and Swedish health care*, Stockholm Studies in Social Anthropology, University of Stockholm.
- Saha S, Komaromy M, Koepsell TD, Bindman AB (1999) Patient physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine* 159:997–1004
- St. Clair A, McKenry L (1999) Preparing culturally competent practitioners. *Journal of Nursing Education* 38: 228–234
- Schultz, D. (2005) Cultural Competence in Psychosocial and Psychiatric Care: A Critical Perspective with Reference to Research and Clinical Experiences in California, US and in Germany. *Social Work in Health Care*, 39, (3): 231-247.
- Skaer TL, Robinson LM, Sclar DA, Harding GH (1996) Utilization of curanderos among foreign born Mexican-American women attending migrant health clinics. *Journal of Cultural Diversity* 3: 29–34
- Skeldon R (2008) International migration as a tool in development policy: a passing phase? *Population and Development Review* 34, 1–18.
- Smith RC (1996) *The Patient's Story: Integrated Patient-doctor Interviewing*, Boston: Little, Brown.
- Stewart AL, Napoles-Springer A, Perez-Stable EJ (1999) Interpersonal processes of care in diverse populations. *Milbank Quarterly* 77: 305–339.
- Street RL Jr (1991) Information-giving in medical consultations: the influence of patients' communicative styles and personal characteristics. *Social Science and Medicine* 32: 541–548.
- Thomas, C., Hosein, R. & Yan, J. (2005) *Assessing the export of nursing services as a diversification option for CARICOM economies*. St Lucia, Caribbean Commission of Health and Development.
- Triandis, H. C. (1995). *Individualism & collectivism*. Boulder, CO: Westview Press.
- Turner, L. (2007) Medical tourism: family medicine and international health related travel. *Canadian Family Physician*, 53, (10): 1639–41, 1646-8.
- UNCTAD-WHO (1998) *International Trade in Health Services. A Development Perspective*. Geneva: UNCTAD-WHO
- Waitzkin H (1991) *The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems*, New Haven, CT: Yale University Press
- Watters C (2001) Emerging paradigms in the mental health care of refugees. *Social Science and Medicine* 52:1709–1718.
- WHO (2006) *Neglected Tropical Diseases. Hidden successes, Emerging opportunities*. WHO/CDS/NTD/2006.2. Geneva: WHO
- WHO (2008) Available at: http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_part4/pdf. [Accessed 7 December 2008].
- Wiese, E.B.-P. (2010) Culture and Migration: Psychological Trauma in Children and Adolescents, *Traumatology* 16(4) 142–152.

- Whittaker A. (2008) Pleasure and pain: medical travel in Asia. *Global Public Health*, 3: 271–290.
- Willen, S.S., Mulligan, J. & Castaneda, H. (2011) How Can Medical Anthropologists Contribute to Contemporary Conversations on “Illegal” Im/migration and Health? *Medical Anthropology Quarterly*, 25, (3): 331-356.
- World Bank (2008) Reshaping economic geography –World Development Report 2009. World Development Reports. Washington, World Bank.
- Wurtz, E. (2005) A Cross-Cultural Analysis of Websites from High-Context Cultures and Low-Context Cultures. *Journal of Computer-Mediated Communication*. 11, (1): Article 13, <http://jcmc.indiana.edu/vol11/issue1/wuertz.html>
- Yeates, N. (2009) *Globalising care economies and migrant workers: Explorations in global care chains*. Houndmills, Palgrave Macmillan.
- Yeates N. (2010) The globalization of nurse migration: Policy issues and responses *International Labour Review*, 149, (4): 423-440.
- Xu, Y., Lippold, K., Gilligan, A., Posey-Goodwin, P., & Broome, B. (2004) A Model for Enhancing Intercultural Communication in Nursing Education, *Home Health Care Management & Practice*, 17, (1): 28-34.