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OVERLOOKING HEALTH ACCULTURATION – A GROUNDED THEORY STUDY ILLUSTRATING THE COMPLEXITY OF INTERCULTURAL CONSULTATION IN SWEDISH PRIMARY CARE

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Overlooking Health Acculturation – a grounded theory study illustrating the complexity of intercultural consultation in Swedish primary care

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By

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ABSTRACT

Background

Intercultural consultations are perceived as complex by physicians and when asked why, ‘cultural differences’ are often mentioned. With increasing patient diversity in primary care, because of increasing global migration, there is a need to address this. Cultural competence has long been considered useful in health care, one reason being that it may aid in addressing disparities of health. Nonetheless, there is no clear agreement on how to facilitate cultural training for family medicine residents.

Aim

The overall aim was to explore the physician-patient interaction in intercultural consultations in primary care, while considering how to apply the findings in a family medicine residency training context.

Methods

A grounded theory approach was used for Studies I and III, in which patients with foreign backgrounds and family medicine residents were interviewed on their experiences of intercultural consultations in primary care. Analysis of the interviews also directed the aim for Study II, a systematic literature review exploring the informal curriculum of family medicine. Study IV was guided by ideas from the previous studies as it included developing and testing the use of virtual patient cases in cultural training in a family medicine context. Data was collected through semi-structured interviews and analyzed using qualitative content analysis. Finally, a core variable theory, generated through grounded theory methodology and based on data from Studies I-IV and additional material, is also proposed in this thesis.

Results

The core variable theory generated in this work was labelled ‘overlooking health acculturation’ and incorporates how acculturation may take place through intercultural interactions in a primary care context but remains unrecognized. Acculturation is an established concept, but health has to the best of my knowledge so far been discussed only in terms of its outcome. This thesis argues it should also be considered a dimension and suggests the concept ‘health acculturation’ to describe changes in an individual’s external practices and internal domains, related to health and illness, when being exposed to another culture.

The core variable theory was built on data from Studies I-IV. Studies I and III identified behaviors and approaches in the consultation which did not seem to facilitate mutual understanding or consider the process of acculturation. Despite general agreement that cultural competence should be part of medical training, in Swedish primary care it has not been applied in a way that residents seem to find relevant; instead, informal learning is relied

on, as illustrated in Study II. Study IV showed that cultural training for family medicine residents may be facilitated through interactive virtual patient cases stimulating discussion and reflection.

Conclusions

This is I believe a first attempt to outline a core variable theory of what happens in the physician-patient interaction in intercultural consultations in a Swedish primary care context. In summary, the process of acculturation was overlooked, possibly reflecting its being disregarded in residency training. To address this, three suggestions on how to facilitate cultural training for residents are proposed: discuss and disclose the informal curriculum, apply existing knowledge on informal learning and add contemporary perspectives on culture, such as the proposed ‘health acculturation’.

Keywords

Family medicine, primary care, culture, acculturation, postgraduate medical education, qualitative research

LIST OF SCIENTIFIC PAPERS

I. Rothlind E, Fors U, Salminen H, Wandell P, Ekblad S. Circling the undefined-A grounded theory study of intercultural consultations in Swedish primary care. PloS one. 2018;13(8):e0203383.

II. Rothlind E, Fors U, Salminen H, Wandell P, Ekblad S. The informal curriculum of family medicine - what does it entail and how is it taught to residents? A systematic review. BMC Fam Pract. 2020;21(1):49.

III. Rothlind E, Fors U, Salminen H, Wandell P, Ekblad S. Primary care consultations on emotional distress – a part of the acculturation process in patients with refugee backgrounds. A grounded theory approach. *In manuscript; under review.*

IV. Rothlind E, Fors U, Salminen H, Wandell P, Ekblad S. Virtual patients reflecting the clinical reality of primary care – a useful tool to improve cultural competence. *In manuscript; under review.*

CONTENTS

LIST OF ABBREVIATIONS

DSM-V	Diagnostic and Statistical Manual of Mental Disorders, 5th edition
GT	Grounded Theory
PC	Primary Care
QCA	Qualitative Content Analysis
VP	Virtual Patient
WHO	World Health Organization

1 PROLOGUE

This PhD thesis is about intercultural consultations in primary care and learning.

Intercultural encounters in general appear to engage people, as many have shared their thoughts on the subject when the topic of my research has popped up in conversations. As a reflection of the growing global migration crisis, it is also an area which has been debated intensely at societal level, by politicians, the media and others. Conducting intercultural research in the current context is challenging, but also rewarding. Nonetheless, exploring culture and related terms is not without controversies. To reduce the risk of being misconstrued, I want to start by emphasizing my position regarding culture and cultural differences, as outlined in a primary care context in this work. While recognizing that cultural differences exist between groups, they also exist within groups. Moreover, the complexity of intercultural consultations is not created in the meeting between two representatives of different groups, but in the meeting between two individuals, each shaped by their respective experiences. What has been described as the anthropological paradox – that the hardest thing to know, and to be able critique objectively, is the subjective nature of one's own culture – has been a personal guiding principle.

The focus of this thesis is the core variable theory labelled 'overlooking health acculturation'. However, while I realize that I might be sticking my neck out, my sincere hope is that this is not misinterpreted as a criticism of the physicians; I am not suggesting that physicians are disregarding this purposely. On the contrary, the informants seemed genuinely concerned for and interested in their patients. Rather, I see it as a reflection of how the medical education system has not yet succeeded in communicating why culture is relevant to consider in the consultation. Medicine has once been referred to as a culture with no culture, but my belief is that this could and should change.

I wish for this thesis to be read both by medical educators and clinically active health care personnel, especially primary care physicians, so that hopefully this work will contribute in some way to improve intercultural training in primary care.

Erica Rothlind

Hammersta, October 2020

2 DEFINITIONS OF CENTRAL CONCEPTS

Acculturation

Acculturation refers in general to the process by which individuals adopt attitudes, behaviors, values, and customs of another culture (1).

Culture

‘A socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life. An individual’s cultural identity may be based on heritage as well as individual circumstances and personal choice and is a dynamic entity’ (2).

Family Medicine and Primary Care

While in other parts of the world primary care fathoms various specialties, such as internal medicine or pediatrics, in Sweden it is virtually synonymous with the specialty of family medicine. Primary care in Sweden is, in addition to prevention and health promotion, responsible for basic medical treatment and rehabilitation not requiring inpatient resources or other skills. By law, outpatient care is given according to medical needs, regardless of other factors (3).

Informal Curriculum

That which is taught outside the formal learning curriculum is often referred to as being part of the informal curriculum. Customs and understandings viewed as common knowledge within a certain field are often mentioned as examples.

Informant

In accordance with the terminology used in qualitative research, informant refers to an individual that participates in qualitative studies.

Intercultural Consultation

A clinical encounter where two individuals from different cultures meet. The term consultation in this thesis refers to a physician-patient consultation in Swedish primary care. For readability, the more general term consultation will be used.

Migrant

The term migrant is an umbrella term which is not defined in international law. The WHO suggests that a migrant is any person who has moved across a border (international or national) regardless of the person’s legal status, cause or voluntariness of the movement and length of stay (4).

Refugee

Refugees are defined and protected in international law. The 1951 Refugee Convention is a key legal document. It defines a refugee as ‘someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion’ (5).

Resident

The term resident refers to a physician doing his or her residency training, which in Sweden is comprised of five years of postgraduate training, regardless of specialty. Unlike in other parts of the world, universities are not involved in residency training in Sweden, instead the responsibility lies with the respective Regions. The National Board of Health and Welfare is responsible for formulating curricula and issuing certificates upon completion. The residents included in this thesis were family medicine residents, but for readability the more general term residents will be used.

Virtual Patient

Virtual patients may be described as ‘case-based interactive computer simulations of clinical scenarios’ (6). They are digital tools used for learning or assessment in a variety of health care specialties.

3 BACKGROUND

As the main focus of the work presented in this thesis was to explore intercultural consultations in Swedish primary care (PC) with a learning perspective in mind, the background will outline the concept of culture and associated terms, and will discuss them in relation to learning theories with focus on postgraduate medical training. First, however, migration will be outlined from a health care perspective, including issues of health disparities, since research indicates that one way to address these may be through providing culturally appropriate health care (7).

3.1 MIGRATION

3.1.1 Migration to Sweden

Sweden is historically a country of migration, changing from an emigrant to an immigrant country in the twentieth century. By the end of 2019, nearly 20% of the Swedish population was foreign-born (8).

Immigration to Sweden has largely reflected international events and conflicts, World War II often being mentioned as a turning point where Sweden shifted to becoming a country of immigration. At that time, immigration was largely made up of refugees coming from neighboring countries, the Baltic countries, Germany, and Eastern Europe. During the strong economic growth in the post-war era, labor migrants were welcomed with few regulations. Following an economic recession, however, regulations were gradually constrained and labor migration decreased in the 1970s (9). Starting in the late 1950s and continuing until today, political persecution and conflicts worldwide have contributed to an increasing number of refugees from Eastern Europe (primarily from Hungary, former Czechoslovakia and Poland), South America and later the Balkan states, the middle East and Africa (9, 10).

In 2015, before policies were changed, an unprecedented number of people (approximately 163.000) entered Sweden to seek asylum (11), reflecting the historically large number of forcibly displaced individuals worldwide, estimated to over 70 million in 2019 (12). In the light of this, increased attention needs to be paid to the significance of receiving countries' resettlement policies, as resettlement-related issues (e.g. family reunion, housing, access to schooling, employment and health care) are not only significant in terms of integration, but also in terms of health outcomes for the individual (13).

3.1.2 Health status disparities and the healthy migrant effect

Migrants are often viewed as a group at risk of disparities of health status, both in terms of the somatic and the psychiatric spectra (14). Meanwhile, this is often acknowledged as too broad a take on a complicated matter, since it does not account for the heterogeneity of the migrant group in terms of reasons for migration, levels of education, time spent in the receiving country, socioeconomic status, etc. (14, 15). Socioeconomic factors have so far

been the focus of most work published on determinants of health, but migration in itself has increasingly also been recognized as a social determinant of health (16).

Research on migrant health patterns tends to show divergent results when exploring differences regarding risk factors for disease and overall health status between migrant groups and the majority population (14, 17, 18). Research on type 2 diabetes provides an illustrative example: migrants are generally mentioned as a group at risk of diabetes (14). Yet, a more nuanced view is provided when exploring this in further detail. Nordic studies have shown increased risk of developing diabetes in non-Western migrants (19). Worse metabolic control and increased risk of complications have also been identified (20). Paradoxically, data has also showed lower cause-specific mortality rates than for native Swedes in this group (21), while in second-generation migrants, mortality rates had equalized (22).

In addition to the diversity of migrant groups and of the contexts in the receiving countries (23, 24), additional difficulties associated with research into migrant health make it hard to draw general conclusions. Examples are briefly outlined below.

First, existing knowledge of migrant health relies greatly on epidemiological studies, with well-known associated pitfalls. For example, registers may not include information on migration status or may use proxies such as country of birth. Consequently, study populations may include an unidentified mix of, for example, refugees and labor migrants (25, 26). Another register fallacy is the so-called ‘salmon bias’, referring primarily to elderly migrants returning permanently to their country of origin while remaining in the registers (27). Although questioned, this bias may theoretically affect interpretations of mortality rates (24, 28). Moreover, the ‘healthy migrant effect’ also needs to be considered; it refers to observations that health status in migrants tends to be better than that of the remaining population of their native country and in some instances better than that of the host population (23, 27). The phenomenon has been explored by several studies and may partly be explained by selection effects of in- and out-migration, but also by register shortcomings (24, 27, 29).

3.1.3 Migration and psychiatric health

Regarding the psychiatric spectra of migrant health research, challenges such as those described above apply. In addition, there is the issue of stigma associated with psychiatric diagnoses likely to complicate the matter further (30-32). Moreover, expressions of emotional disorder are not universal (30, 33). Expressing diffuse pain is for example often used to communicate emotional distress or depression (33-36) though it is not included as a criterion for depression in the widely used Diagnostic and Statistical Manual of Mental Disorders (DSM) (37). The DSM has received repeated criticism for its cultural bias and in response the Cultural Formulation Interview was introduced in DSM-V as means to facilitate intercultural medical communication (37, 38). Evaluating studies indicate it may be helpful (39, 40).

Diagnostic difficulties aside, a large body of research indicates that, in general, refugee populations present with a higher prevalence of emotional disorders such as depression,

anxiety disorders and posttraumatic stress syndrome than does the general population (13, 32, 41-44). Exposure to stressors and trauma during different phases of migration (pre-migration/migration/post-migration) is a probable cause (13, 41, 43, 45).

While it has been suggested that emotional disorders in this population may be under-diagnosed in PC, Sweden included (46), there is also worry regarding diagnostic labeling of distress, with the risk of pathologizing reactions that may be considered normal responses to abnormal circumstances (30, 47). The National Board of Health and Welfare estimated in a report published in 2015 that approximately 20-30% of those seeking asylum in Sweden were suffering from emotional distress, although it was emphasized that this did not necessarily mean they all fulfilled criteria for a psychiatric diagnosis or needed health care (46).

3.1.4 Disparities of health care in Sweden

Health care disparities refer to differences between groups in access to health care (7). A complex and interrelated set of legal, societal, health-system and individual factors contributes to disparities arising, with patterns varying across and within nations (14, 16). This complexity also makes it difficult to establish what differences should be regarded as actual disparities, as opposed to warranted differences arising from medical needs differing (48).

Nonetheless, refugees and undocumented migrants have been identified as groups at particular risk of suffering health care disparities (49). In general, they have lower health literacy which may affect health-care-seeking behaviors (50-52). An issue peculiar to the Swedish context is a phrasing used in the laws regulating the access to care for undocumented migrants and asylum-seekers, which allows subjective interpretations: it states that they have the right to 'treatment that cannot be deferred' (in Swedish 'vård som inte kan anstå') (53, 54), a phrasing which the National Board of Health and Welfare has deemed a risk to patient safety, as it is not line with medical ethics (55, 56). Reports indicate that interpretations vary, not only on individual level, but also regionally (55, 57).

3.1.5 A primary care perspective – emphasizing the consultation

Primary care is, worldwide as well as in Sweden, considered a key player in migrant health and in evening out the differences in health disparities (48, 58). This is because it is generally the main provider of health care and in many instances also the first point of contact with the health care system (48, 58). As an introduction to the health care system in Sweden, all asylum-seekers are supposed to be offered a medical check-up at a PC center. During the past ten years, however, participation has on average barely reached 50% in Region Stockholm (59). In addition to logistic problems, communicative issues have been suggested to explain the low attendance (59).

Relevant communication skills are essential when working in PC. The consultation, with focus on patient-centering, is considered an important diagnostic tool for family physicians, failing communication here negatively affecting the quality and outcome of care (60-62). The

weight attributed to the consultation is also reflected in the mandatory courses for family medicine residents in Sweden, specifically addressing patient-centered communication (63).

Patient-centeredness is a concept coined by Balint (61). It emphasizes that each patient is a unique individual (61). With time the concept has been developed and contemporary definitions also stress increased patient engagement and ideas of shared responsibilities (62, 64, 65). Although the concept has been promoted by medical educators during the past few decades, it is not universally applied and in some parts of the world a paternalistic style of communication prevails (66, 67). Although, in theory, a participatory style of communication may be favored, to implement it on a worldwide scale additional barriers need to be addressed: lack of preparedness in the patients has been mentioned (66), and this may be worth considering particularly in intercultural consultations.

Even though much thought has been put into the consultation as such, it has also been suggested that further exploration of what takes place on an interpersonal level may partly explain some of the health care disparities otherwise unaccounted for (48). Meanwhile, acquiring knowledge of intercultural consultations is not a mandatory part of the Swedish residency curriculum, even though cultural differences and lack of knowledge in how to address these, are often mentioned when their perceived complexity is discussed (68-70).

3.2 CULTURE

3.2.1 The understanding of culture in this thesis

The concept of culture is complex, its definition lacking a clear consensus. The understanding and use of the concept among academics from different disciplines varies and is likely to differ from that of most laypeople. A definition agreed useful in the context of medical education is the following: ‘Culture is a socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life. An individual’s cultural identity may be based on heritage as well as individual circumstances and personal choice and is a dynamic entity’ (2). This definition forms the basis for the understanding of culture in this thesis.

Historically, the concept of culture has carried different meanings and implications, some of which are still reflected in current interpretations. A full account is beyond the scope of this thesis but an example from the nineteenth century is highlighted as it still has bearing on the way culture is considered today. In short, when colonial-era anthropologists developed the idea of culture as a scientific tool, they used it to describe how the way of life of other, often so-called ‘primitive’, people differed from their own, often Western European civilization (71). Today, this outside perspective still lingers, and one could argue that it facilitates the view of ‘others’ having a culture, while hindering us from reflecting on our own (2).

Being an immigrant is often seen as synonymous with having a different cultural background from that of the majority population. This assumption is also inherited in theories of acculturation discussed below. Biculturals, or individuals with broad knowledge of two

cultures, such as migrants, have also been the focus of research on ‘multiple cultural identifications’ (72). But biculturalism is just one of many shapes of plural identification: variations within groups and/or overlapping between groups must also be accounted for (72). Nor is the culture an individual grows up with a constant entity – rather, the dynamics in the process of adapting to new environments should be considered, especially when discussing culture in the context of migration. Accordingly, in line with central claims of modern anthropology, culture should not be equated to ethnicity or nationality (73, 74).

3.2.2 Microcultures

Adding yet another dimension to the pluralistic view of culture described above, the concept of ‘microcultures’ may be considered (75, 76). It refers to how groups based on for example their belonging to a profession, also share practices and behaviors which are not necessarily part of the general cultural context (76). Physicians being fostered in a dominant culture of biomedicine is one example. Thus, in addition to a more general cultural context, everyone also belongs to several different microcultures, where communication and interaction representative for that particular microculture take place (75, 76).

3.2.3 The use of culture in a health-care context

The need to incorporate a cultural perspective into health care was identified in the 1950s in order to cater for cultural differences, with the concept of cultural competence originally introduced as a framework for health care professionals working with migrants (77). Over time, however, the concept has evolved and expanded from the interpersonal domain to include health care structures and issues pertaining to minorities in general (65). In addition, there is still discussion on what the concept should encompass, adding to its complexity.

A systematic review exploring cultural competence by outlining its most common dimensions as found in the literature, concluded that cultural awareness, knowledge, and skills are three components frequently recurring (78). Meanwhile, it also highlighted the contradictory fact that most of the conceptual models of cultural competence were based on the authors’ personal experience or literature reviews (78). The models are thereby likely to reflect the cultural context in which they were developed, with the risk of promoting a one-sided perspective, contrasting its fundamental ideas (78). Appropriating, rather than respecting, the other’s culture has also been mentioned as a potential negative consequence of emphasizing ‘competence’ in this context (79).

In response, alternative but related concepts such as ‘cultural safety’ and ‘cultural humility’ have been introduced and suggested as more suitable concepts for health care and medical education, (80-82). They share a common focus on redressing power imbalances in the physician-patient dynamic (80, 82). Though not as widespread as cultural competence, these concepts are mentioned here to illustrate another facet of the subject matter, reflecting its complexity.

While recognizing the existence of other related concepts, this thesis will use cultural competence when discussing learning objectives in intercultural training for residents, as it is considered well-established. Even so, the literature on how to incorporate cultural competence in practice and in residency training in PC is limited (83). The complexity of this concept is also mirrored in how intercultural consultations are experienced.

3.2.4 Experience of consultation in culturally diverse primary care

Studies exploring experience of intercultural consultation have increased in the past decade. Family medicine is an area of particular interest, with PC often serving as the initial point of entry to the health care system (58). A recurring theme in previous studies on intercultural consultation has been barriers to interpersonal communication: language barriers and the need for interpreters are evident examples, but issues pertaining to culture have also been raised (58, 69, 70, 84, 85).

Studies exploring the views of physicians show that they find intercultural consultation complex (68, 84-86). Both specialists and residents describe it as stressful, probably in part due to a supposed lack of knowledge and skills (87, 88). Moreover, an inclination to avoid addressing cultural issues, even when they seem central to the consultation, has been noted (69), as well as a tendency of residents and patients to blame each other for communication problems (89).

Exploring experience of intercultural consultation from a patient perspective, a systematic review summarized that patients perceived communicating with physicians as challenging, for the following reasons: ‘language barriers, discrimination, differing values, and acculturation’ (90).

3.3 THE CONCEPT OF ACCULTURATION

3.3.1 Theories of acculturation

Acculturation broadly refers to the process by which individuals adopt attitudes, behaviors, values, and customs of another culture (1). Contemporary use of acculturation often mirrors current thinking about culture in more pluralistic terms as described above (72). This is, for example, reflected in the term ‘professional acculturation’, dealing with the socio-cultural learning involved in training to be a physician (91). While agreeing with this conceptualization of acculturation, the present author will refer to the process of change taking place in the patients.

Originally, the concept of acculturation was coined in the field of anthropology to describe cultural changes on group level. It has historically been viewed as a unidimensional process with the minority exchanging their original culture for that of the majority (92). Contemporary research has highlighted the problematic aspects of this viewpoint in that it reflects outdated colonial thinking; subsequently, bidimensional models have been

developed, emphasizing that the process of adopting elements of another culture does not require shedding old ones (1, 93, 94).

When the term acculturation was adopted in psychology, there was also a shift from describing changes on group level to focusing on the individual (95). A widely accepted conceptualization of acculturation in the past decades is Berry's theoretical framework (1, 95). This encompasses three main features: '(1) what changes during acculturation; (2) how people acculturate; and (3) how well people adapt to acculturative change' (1, 93). What changes is often organized into practices, values, and identification. How people acculturate is examined through acculturation strategies (1). The model outlines how an individual's stance between the retention of heritage culture and the acquisition of mainstream culture theoretically results in one of four possible outcomes: integration, assimilation, separation or marginalization (1, 93). Whether these four categories exist in practice and are equally valid has, however, been questioned (96), as has the wording 'strategies', which may imply that individuals' specific choices guide differences in acculturation outcomes, irrespective of contextual circumstances (94).

It has also been suggested that the process of acculturation depends on 'the social capital' of the individual, such as level of education, economic preconditions and language skills (97); this although, the influence of macro-level variables, such as governmental policies, residential segregation and the existence of discrimination in the labor market, have increasingly been recognized (72, 98).

Acculturation research has generally assumed that changes in practices, values, and identification occur independently and at different rates in different individuals (1, 93). This has now been questioned, since such assumptions do not account for possible interrelations; that is, do changes in cultural practices drive changes in cultural identities or the other way around (94, 95)? Berry's model of acculturation has received criticism for not addressing this, along with disregarding the context in which interaction occurs, mechanisms of change, and internal changes (72, 94, 95, 98-100).

3.3.2 Internal or emotional acculturation

It has been suggested that in addition to external aspects, such as practices and behaviors, internal domains, such as attitudes and feelings, also change in acculturation (99, 101). The term emotional acculturation refers to emotional patterns changing as individuals come into continuous contact with another culture (99).

Cultural psychologists argue that different cultural contexts promote 'different ways of being and acting in the world' (95) as various internal aspects, such as cognition and emotion are fostered by culture (95, 102). The concept of emotional acculturation illustrates how people, engaging in similar cultural contexts, experience more similar patterns of emotion. It has been suggested that individuals subjected to similar signals that serve to up- or down-regulate emotions, are likely to respond accordingly and, collectively, 'culturally congruent' emotions will be promoted (103). Thus, various emotions are typically more or less rewarded in

various cultures and those promoted are also suggested to be experienced more frequently (100, 104).

The term emotional concordance has been suggested to describe how well an individual's patterns of emotion correlate with that of the majority culture (99). Research has however pointed to difficulties in assessing this, since changes in internal domains may not be related to explicit attitudes toward adopting new values or traditions (99, 105).

3.3.3 Acculturation and health outcomes

The concept of acculturation has gained interest in public health and medicine, partly because it is suggested to be of significance in the context of health disparities (98, 101). Literature on acculturation and health outcomes often mentions acculturative stress, as a detriment in health status related to acculturation (106), although several aspects of this phenomenon have been criticized (107). For example, if health consequences (such as high blood pressure) are the measured outcome, then what is caused by acculturative stress cannot be differentiated from what is caused by a change in cultural practice (107). There is also the risk of confounding causes and consequences; acculturative stress is presumed to cause illness, but illness as such can also cause stress (107).

Others have suggested that a discordance in the individual between the internal and external aspects of acculturation could be a source of stress, possibly resulting in adverse health effects (101). Meanwhile, evidence does not support the idea that the process of learning a new culture itself causes long-lasting stress (72).

There is, however, a need to unify theoretical models concerning the mechanisms underlying how acculturation might affect health (98, 108) as studies to date show contradictory results (98, 101, 108). To illustrate, acculturation has, for example, been associated with better, worse and no difference in glycemic control among Hispanic Americans (109-111). In general, the use of various proxy-measures for acculturation, such as language and duration of residency, probably accounts for some variations (94, 101). Moreover, despite empirical evidence favoring bidimensional approaches, unidimensional models continue to be often used in epidemiological studies, limiting our understanding of whether it is the loss or acquisition of a certain practice that is of the essence (94).

Moreover, in order to better suit the purpose of health research, some argue that a re-construction of the concept is needed (98, 101); for example, a shift towards a more multidimensional model has been suggested (94, 98).

3.4 LEARNING ASPECTS OF CULTURE

In general, the present work deals with two aspects of learning: learning in residency with focus on intercultural training and learning from a patient perspective in terms of acculturation. These will be discussed below.

3.4.1 Learning theories applicable in residency training

Various learning theories are applicable on different levels of medical education, with learning conditions and the need for support differing widely between medical school and postgraduate training. In general, progressing through these levels involves increasing reliance on experiential learning (112). Experiential learning theories are the focus of this section as they are applicable when exploring resident training, with learning occurring mainly in the workplace through practice and interpersonal interaction (112, 113).

Experiential learning theories view education as a process of individual transformation in reaction to experience and perception (112). It is an active process where experience must be interpreted and integrated with prior knowledge for new knowledge to be gained, reflection being central (114). These theories build on the philosophical principle of constructivism which emphasizes the co-construction of knowledge and acknowledges that several competing truths may coexist (112, 115).

A model traditionally associated with experiential learning, often referred to in medical education literature, is Kolb's learning cycle (116). It illustrates how personal interpretation of experience guides actions that lead to new experience in a four-stage cycle: concrete experience – reflective observation – abstract conceptualization – active experimentation (116). The work of Knowles, centering on adult learning, is also central to medical education (117). These educational theorists are seen as representing a cognitive perspective on experiential learning, which focuses mainly on what happens in the individual during the process of learning (112).

Another perspective theorizing experiential learning and taking social and cultural context into account, is socio-cultural learning theory, with Vygotsky traditionally seen as its founder (112, 118). Central tenets here are that learning is essentially a social process. Experience alone is not enough for creating meaning; rather, the context in which learning takes place and social and cultural interaction with others are of the essence (118).

Contemporary perspectives on socio-cultural learning theory also highlight activity, referring to 'goal-directed joint activity', as central (119). In addition, so called communities of practice, in which learning, and identity intertwined with practice are significant (120). From a resident perspective, a PC center would then be considered a community of practice, where the resident would be viewed initially as a novice member, progressively gaining independence and self-direction through experience and participation in that community. With time, there will therefore, theoretically, be a decreasing need for supervision (121).

3.4.2 Experience-based and informal learning

Theoretical explanations, as those outlined above, have in common that they describe what would happen given ideal circumstances. Meanwhile efforts have begun to address what actually happens in terms of learning in the clinic throughout the course of medical education (122-124). A model referred to as 'experience-based learning' has been suggested, which

largely fits with the experiential learning theories discussed previously (112, 123, 125). For example, learning is described in terms of participation supported by the environment, including the steps: observing, rehearsing and contributing, reflecting ideas of socio-cultural learning theory (112, 120, 123, 125). Rather than referring to clinical teaching, experience-based learning suggests 'pedagogic support' and so-called informal learning is considered to dominate over formal teaching (112, 123, 125).

Informal learning has been described as learning 'taking place in the spaces surrounding activities and events with a more formal educational purpose' (126). The term is difficult to fully grasp because what goes on is often not recognized as learning and the result not regarded as something that has been learned, but seen rather as part of a person's general ability (126). In residency, informal learning is of particular interest since much learning takes place in the workplace, outside formally organized curricula (112). This needs to be considered when addressing gaps of knowledge in this group, such as cultural competence discussed below.

3.4.3 Intercultural training for residents

Informal learning is likely dominant in intercultural training for residents as formal activities appear limited (83, 87, 88, 127). The important role of the supervisor has been highlighted, since without appropriate facilitation of learning there is a risk of 'ad hoc coping behaviors' developing, rather than cultural competence being gained (83). Unfortunately, studies also suggest that supervisors in general find culture a difficult area to address and inadequate education of the educators has been identified as a barrier to improved cultural competency training (7, 128-130). Not surprisingly, residents generally also feel their intercultural knowledge is insufficient and desire more training (83, 87, 88, 127). Meanwhile, studies also indicate an ambivalence in residents towards formal training, one concern being a risk of that training resulting in increased stereotyping (87, 89, 127).

With increasing patient diversity in PC during the past decades, there has been a call for improved intercultural training, but evidence for the effectiveness of various educational approaches is still scarce (7, 83, 131). A key challenge is to balance generic consultation knowledge with more specific knowledge applicable in intercultural consultations, without reinforcing stereotypic ideas (131, 132). No consensus has been reached on how to achieve this; various educational approaches and methods of teaching have been applied. The positivist approach and the social constructionist approach serve as broad illustrations of the diverse ways in which the issue has been addressed (2).

The positivist approach reflects biomedical teaching in that it is fact-driven and assumes that absolute truths exist and can be learned (2). A basic principle is that just as checklists of symptoms for a disease can be learned, so can checklists of cultural markers; a familiarity with these would then assist the physician in identifying which cultural group the patient belongs to (2). Accordingly, the patient's worldviews and explanatory models will then also be known to the physician, enabling a shared understanding (2). This approach has received

criticism for being too narrow, while at the same time reinforcing broad generalizations about 'others' (i.e. the notion of 'others having a culture' as mentioned above) (74, 80).

The social constructionist approach emphasizes the avoidance of checklists and opposes the notion of an absolute and objective truth (2). It appreciates that different individuals will interpret the same event differently and that the context needs to be considered (2, 133). Practicing self-reflection is often emphasized in this approach, since identifying one's own biases is considered a prerequisite to successful intercultural consultations (133, 134).

Further, within these two approaches, a range of teaching formats has been applied, but again evidence is scarce for which is more efficient, and patient-related outcomes are generally lacking (2, 83, 135). It has however been suggested that interactive methods employing the use of e-learning may be valuable complements to traditional lectures; the latter generally considered useful for introducing topics but not for changing attitudes (2, 136-139).

3.4.4 Intercultural training through e-learning

Intercultural training may be facilitated by digital education. Digital education, or e-learning, is an umbrella term for a variety of educational approaches and methods used for teaching and learning through digital technologies (140). Examples range from online courses and webinars to virtual reality and virtual patients (140).

Virtual patients (VPs) are case-based interactive computer simulations of clinical scenarios aimed for learning or assessment (6). Their use in medical education builds on experiential learning theory which fits well with residency training, as discussed previously. VPs may facilitate activity and reflection, both central parts of experiential learning (116, 119, 141). Theories of adult learning, stemming from experiential learning, state that learning is enhanced when the learner is taking active part in real-life settings (117), and this applies to VP-based training.

VPs can be used as a part of various educational activities and greater exploration of these possibilities has been advocated (142, 143). In general, VPs are considered superior to passive forms of educational activities, such as lectures, in changing attitudes or practicing clinical reasoning – both highly relevant in intercultural training (144). Another interesting aspect of VPs is that they easily can be targeted towards special educational needs, such as ethics and encounters with traumatized refugees (145-147).

3.4.5 Learning acculturation?

Acculturation, as discussed previously, deals with changes in external and internal domains when someone comes into continuous contact with other cultures. As previously mentioned, its application in this thesis is limited to the process of change taking place in the patients. This includes discussions on learning perspectives.

To further elaborate on the 'how' of acculturation (Berry's strategies having been criticized as mentioned for being too limited), research has also begun to explore how acculturation

may occur in terms of learning. Both explicit and implicit learning processes may be at work (72, 95).

Explicit learning processes such as imitation and instructions have been emphasized when for example acquiring new cultural practices e.g. a greeting procedure (75, 95). However, implicit learning processes might be of greater significance than previously thought (72, 95, 100), observational learning being one example (148). Observational learning is part of Bandura's social learning theory and involves learning through observing others, integrating the information, and replicating the observed behaviors (148). Unlike in imitation, motivation is considered an important component, and a duplication of the behavior is not required (148).

In summary, intercultural consultations are complex, but studies outlining theories explaining why are lacking. Physicians express a wish for improved intercultural training but there is no clear consensus on how this should be achieved. Exploring the physician-patient interaction in the consultation, using a grounded theory perspective, may provide new insights on this perceived complexity, and may contribute to adding new perspectives on intercultural training.

4 AIM

The overall aim was to explore the physician-patient interaction in intercultural consultations in PC, while considering how to apply the findings in a residency training context. This was achieved through four sub-studies, addressing the following specific aims:

- Study I: to explore intercultural physician-patient communication in primary care consultations, generating a conceptual model of the interpersonal interactions as described by both the patients and the physicians, using grounded theory methodology and taking both perspectives into account

- Study II: to explore the informal curriculum in family medicine with respect to the following: what elements of the informal curriculum are applicable in a family medicine context and what educational interventions for family medicine residents, visualizing the various educational elements of the informal curriculum, have been performed?

- Study III: to explore physician-patient communication, with focus on cultural aspects of emotional distress in intercultural primary care consultations, using a grounded theory approach, considering both the physician's and the patient's perspective

- Study IV: to explore a learner perspective on the educational use of a VP-system designed to contribute to training in cultural competence in a PC context

5 METHODOLOGICAL CONSIDERATIONS

5.1 THEORETICAL CONSIDERATIONS

All research studies are conducted within a paradigm, or a system of beliefs for understanding the world. Research paradigms have been described as frameworks guiding the researcher on the theoretical perspectives on ontology, epistemology, methodology and ethics (149). Ontology refers to the assumption of the nature of reality and epistemology to the nature of knowledge, or the relationship between the researcher and this reality: how the researcher knows the world (149). Methodology refers to the techniques used for gathering knowledge about reality, whereas ethics regards the fundamentals of the role and responsibility of the researcher (149).

Quantitative methodology, which is anchored in the positivist paradigm where objectivity and the existence of one true reality are essential assumptions, is commonly used in medical research (149). A further elaboration is beyond the scope of this thesis, but the fundamentals are mentioned as they contrast those of the constructivist paradigm on which this thesis builds.

5.1.1 The constructivist paradigm

The main reasons for choosing to conduct the research for this thesis within the framework of the constructivist paradigm were twofold: the topics and my own position.

Intercultural consultation and residency training were central to this work from the start. Both rely on information being gathered, constructed, and understood through various forms of interaction. This is in line with the relativistic ontology of constructivism, which sees realities as constructed by individuals in interaction with each other and their surroundings: it is context-dependent (149, 150).

The epistemology of constructivism stresses subjectivity, in that knowledge is understood and co-created in the researcher's interaction with the data (149, 150). This includes the process of analysis. Allowing for subjectivity was essential, considering my position as a specialist in family medicine.

The methodologies used in constructivism are interpretive, or hermeneutic. Constructivism is often associated with qualitative methods but not exclusively so (149, 150). This work applied two different qualitative methods; grounded theory (GT) and qualitative content analysis (QCA), which are outlined below.

5.1.2 Symbolic interactionism

Symbolic interaction is briefly mentioned since it has been an underlying perspective for this work, as my understanding of culture is in line with this framework, viewing it as dynamic and actively constructed in social interactions.

Symbolic interactionism is a theoretical framework derived from the philosophical tradition of pragmatism (151). It emphasizes social interaction as a base for understanding the self and reality, with language and symbols playing crucial parts; reality is thus contextual and human actions are based on co-constructed meanings (150, 151). Although sometimes outlined as the underpinning philosophy of GT, the assumptions of symbolic interactionism were introduced at a later stage (150). Although Glaser – one of the founding fathers of GT – referred to it as 'aphilosophical', he granted that symbolic interactionism could be viewed as a 'sensitizing agent' (152). It has also been referred to as a 'perspective' guiding theoretical thinking about data (150).

5.2 OVERVIEW OF STUDIES

The present work consists of four studies with variations in designs and methods, but with an overarching principle of being explorative in nature. An overview is presented in Figure 1.

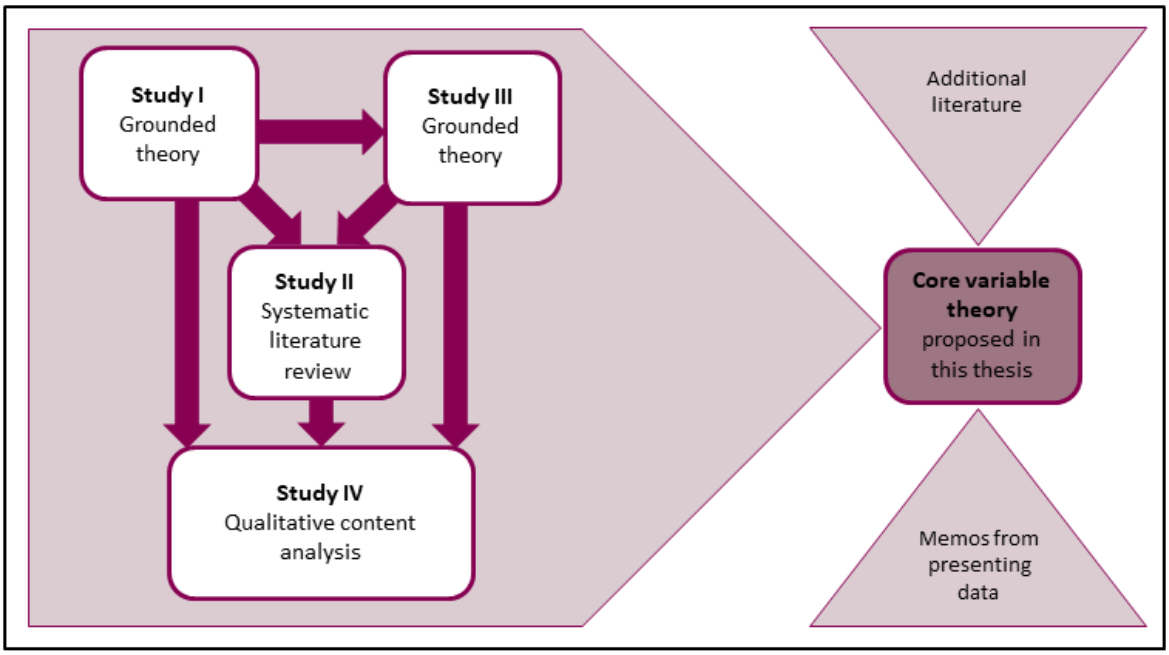

Figure 1. A schematic overview of the relationship between the four studies and the core variable theory.

In Studies I and III, residents and foreign-born patients were interviewed about their experiences of intercultural consultation in PC using a GT approach. The analysis of the interviews generated the topic for Study II, which was a systematic literature review. Studies I, II and III also guided ideas for Study IV, in which interactive virtual patient (VP) cases were developed and ideas on their potential use in intercultural training in a family medicine context were explored through qualitative content analysis (QCA). The four Studies (I-IV), together with memos from literature and presentations of data at for example conferences and courses, also formed the basis for the core variable theory proposed in this thesis. This process is described further in section 5.8.

5.3 STUDY SETTING AND CONTEXT

5.3.1 Primary care setting (micro-setting)

Studies I and III were conducted in a PC setting in the Stockholm region. The PC centers, where the informants were either employed as residents or listed as patients, were distributed in different parts of the city and suburbs. They were sampled to ensure a variation in size, demographics, and socio-economic characteristics.

5.3.2 Macro-context

The macro-context in which this research has taken place has been quite extraordinary, both with strong focus in the public debate and politics on issues related to migration, and considering that policies, and public opinion, on migration shifted significantly and fairly rapidly.

Nevertheless, the increase in immigration to Sweden over the past few years has highlighted the need for improved integration, where access to equal health care is an important factor, with PC being a key player (153, 154). Under the Health and Medical Services Act, the health care system in Sweden is also committed to providing equal health care based on medical needs, regardless of social or economic status (3). There is, however, concern regarding a possibly increasing difference in access to health care: more affluent groups with a generally lower burden of disease may have benefited at the expense of patients with more complex needs, such as migrants (48, 155, 156).

5.4 THE RATIONALE FOR USING QUALITATIVE METHODOLOGY

The overall goal of qualitative research is to develop concepts that help us understand social phenomena as experienced by individuals themselves, in their natural context (157, 158). Qualitative methods are suitable when exploring new and/or complex phenomena not amenable to quantitative measurement. Issues pertaining to culture are one example. In general, qualitative methodology involves systematically collecting, organizing, and interpreting data, which is often (but not necessarily) derived from interviews or observations (158).

The PC setting has several preconditions that make a qualitative approach suitable. In theory it offers the possibility of seeing patients in their social contexts and following them over time. Patients seldom present with one identified disease; instead the clinical image is often complex, with multimorbidity and undifferentiated symptoms being highly prevalent (159). Medical conditions are also often mixed with non-clinical problems, and this might influence how symptoms are presented and interpreted (160, 161). Here qualitative methods may be useful, since they offer the possibility to add to clinical knowledge beyond what could be measured quantitatively. They also fit well with the fundamental idea of family medicine: seeing the patient as an individual in his or her context (162).

5.5 A GROUNDED THEORY APPROACH (STUDIES I AND III)

As GT was the methodology of choice for the greater parts of this work, it will be the focus of the following section and serve as a point of reference when discussing the other methods applied.

GT is mainly an inductive method for constructing conceptual frameworks, or theories, from data and subsequently checking their theoretical interpretations (150). It generates hypotheses or theories, rather than producing data based on pre-existing knowledge or theory. A GT approach was used for Studies I and III, and for generating the core variable theory presented in this thesis. Sections 5.5.2-5.5.6 highlight aspects that are peculiar to the methodology and discuss how they were considered.

Sections 5.6 and 5.7 then outline the procedure of the literature review (Study II) in relation to GT and briefly discuss and contrast content analysis (Study IV) to GT. The process of generating a core variable theory is described in sections 5.8 to 5.10, followed by a reflection on ethical considerations in section 5.11.

First, however, a short note on my understanding of the constructivist GT approach which was chosen for this research.

5.5.1 The rationale for a constructivist approach

Choosing a constructivist approach might not be the conventional choice, as constructivist GT has evolved as an alternative to the classic objectivist form (150). However, when reflecting initially on the preconditions for this work, my own position as a specialist in family medicine, the nature of the main topics, and the decisions taken on how to gather data, a constructivist approach seemed more suitable.

Such an approach emphasizes the co-construction of data; the theory being a product of the interaction between the informants and the researcher, recognizing that theorizing occurs under particular social and situational contexts (150). The resulting theory is an interpretation – it cannot stand completely free of the researcher's view, even when she or he strives to be an unbiased observer (150). Intercultural consultations at the core of this work and my understanding of culture as being generated in interaction, did not fit a strict objectivist view that would assume an 'external reality' where social context is erased.

Interviewing as the main method of gathering data was also selected early in the project, as it was deemed the most feasible way of obtaining information. While a constructivist approach recognizes that for certain research topics interviews are more effective for obtaining data (150), classic GT, with its roots in sociological field studies, emphasizes observational data (163). At the stage of planning this work the latter did not seem optimal. The researcher as a third party observing an authentic consultation was in this case reckoned to inhibit the physician-patient interaction while not getting the depth of data needed for an adequate analysis.

5.5.2 Data collection through interviews

Interviews constituted the main source of data. Research interviewing has received criticism from several disciplines, often with focus on notions of accuracy. In summary, interviews are retrospective narratives and what people say may not accurately reflect their actions (164, 165). On the other hand, interviews arguably fit the methodology well, facilitating open-ended and in-depth exploration of an area (150). Although this is not recommended in classic GT, the interviews in this work were recorded and transcribed (163). The main reasons were that (master-level) medical students partly assisted with the interviews and to enhance transparency of the scientific work.

For a physician, there is a built-in risk of power imbalance in the interview situation with patients. In addition, the interviews were also meant to capture the informants' experience of the physician-patient interaction in the consultation, a potentially sensitive subject. This was reflected upon early in the project and led to a decision to have medical students assist, under supervision, with the initial interviews. They also interviewed the residents on the same topic, since they were considered more neutral interviewers than myself. Being a colleague might, for example, have generated less detailed information since a shared understanding could easily be presumed.

However, as the analysis progressed, the interviews were conducted by the author as the method allows for adding focused questions based on emergent categories. Here theoretical sensitivity is required (150). A focus-group setting was chosen to compensate for the power imbalance mentioned previously, and the main supervisor, with a different profession (clinical psychologist), also acted as moderator. Again, this is not a conventional choice as focus-group interviews are not recommended in classic GT; but with the existing preconditions it did seem a better option for generating rich data (163, 166).

Field notes were also used, although sparsely, since they are often viewed as selective and biased by the research community (163).

5.5.3 Allowing for emergence

To allow for emergence and avoid data being forced into preconceived categories, questions were formulated broadly. The original idea was to interview physicians and patients for separate analyses, but as the interviewing and analysis began in parallel, patterns emerged which led to a change of plan. Behaviors mirroring each other, and a seemingly shared main concern, led to the incorporation of both the physicians' and the patients' accounts in the emerging categories.

Allowing for emergence is also a prerequisite for allowing for a main concern to appear. The main concern is a concept central to GT as the methodology seeks to conceptualize the problem as experienced by the informant (163). Nonetheless it has been questioned; for example, questions as to whose main concern is actually captured have been raised (150) but addressing this problem is beyond the scope of this thesis. On the other hand, informants in

general will, arguably, not have much to say about a topic they do not perceive as a concern (152). One example in the present work would be the aspect of gender and its possible effect on the consultation. Prior to starting the interviews this was thought to be an area of concern. But as it turned out, for the informants it was not. Thus, in line with the methodology, gender did not form part of the analysis.

5.5.4 The iterative process of data collection and analysis

GT is a methodology emphasizing an iterative process of data collection and analysis. Data analysis (for Studies I and III) used initial, focused coding, and categorizing in accordance with GT as outlined by Charmaz (150). Constant comparison ensured that the emerging codes and categories were well-anchored in the original data, although at a higher level of abstraction as the analysis progressed. This included theorizing, which involves new ideas being formulated through abstractions and then tested against the original data (150). The iterative process continued until theoretical saturation was reached, that is when additional data no longer generated new theoretical insights (150). This is by default a subjective concept, nonetheless the gold standard in GT when deciding when to stop gathering data (150, 163).

In addition, I would emphasize that in GT the units of analysis are the incidents found in the data (150). The number of informants is consequently of less interest than the number of incidents they each contribute, which greatly varies.

5.5.5 Theoretical sampling

Theoretical sampling was applied as the analysis progressed in accordance with the methodology of GT (150). It is a process where sampling is guided by the emerging categories. This to delimit data as well as to develop the properties of the emerging categories or theory (150). Thus, theoretical sampling can only be employed after a tentative theoretical category has been developed from the data (150). It differs from initial sampling in which criteria are established to address the research question (150). Choosing residents as a target group was in this case an example of a decision made in the initial sampling process, as they were deemed likely to be able to contribute with information on intercultural training, in addition to sharing their experience of consultations. Likewise, foreign-born patients, identifying themselves as refugees, were of interest since they have been identified as a group at risk of suffering health disparities, as discussed previously.

Although, as mentioned, GT is mainly an inductive method, applying theoretical sampling involves abduction which is a form of reasoning requiring ‘an inferential leap’ (150). Abductive reasoning involves considering different possible theoretical interpretations of surprising findings, then forming hypotheses and re-examining the data to see if a plausible theoretical interpretation can be made (150). One example from this work was how the emergence of the tentative category ‘experiencing a process of change’ directed the theoretical sampling to literature from nearby fields of knowledge theorizing behavior, which

in turn contributed with theories of acculturation. These were used as a lens for viewing the data, which allowed for further development.

5.5.6 Memo-writing and language used

Memos were written continuously throughout the research process and form the basis of the analysis. The purpose of writing memos is to raise the material to a more theoretical level (150). A typical memo in this work was written in 'Swenglish' and consisted of a couple of paragraphs, outlining ideas and thoughts originating from quotes from the interviews, or particular wordings used by the informants such as 'process of integration', or ideas sparked by related concepts from the literature. Through continuous and extensive memo-sorting, patterns generating the concepts and core variable theory emerged.

Swedish was used in the initial stages of analysis as coding in the language of the interviews helped the coding to correspond more closely to the data. As the analysis progressed, English was also used for naming categories. The use of language is central to the analysis, and changing language inevitably changes nuances in the content. In addition, considering language an instrument for understanding and constructing a new cultural context, particular care had to be taken to avoid misconstructions when informants were not interviewed in their own language (73). Awareness, discussion with colleagues, using native speakers to translate certain quotes, and applying language review, were measures taken to compensate. Further, certain issues need to be addressed when using interpreters. These are discussed in the Ethics section 5.11.3.

5.6 CONSIDERATIONS OF THE SYSTEMATIC LITERATURE REVIEW (STUDY II)

In classic GT the literature review is not conducted until the core concepts of the theory have emerged. This is done to avoid importing preconceived ideas (163). More recently, this idea has been rejected by some with the argument that a lack of familiarity with relevant literature is no longer feasible in today's research climate (167). In the present work, the literature search was delayed until the categories for Studies I and III started to emerge, as prior to that it was not clear which substantive area to focus on.

When the categories for Studies I and III started to emerge, the literature search initially focused on similar terms, which in turn led to articles on cultural competence and the informal curriculum. A gap of knowledge was identified when trying to understand what the informal curriculum of family medicine actually entailed and whether any formalized educational interventions had been attempted. Consequently, a systematic literature review was conducted, trying to fill that gap.

The aim was here to provide a synthesis of what the informal curriculum of family medicine entails, and a diversity amongst study designs was anticipated. Hence, a narrative approach was chosen, rather than a meta-analysis (168). While recognizing that this approach may limit the possibility to draw firm conclusions, it was deemed the most feasible option.

In addition, to assess the impact of educational interventions aimed at formalizing parts of the informal curriculum, Kirkpatrick's hierarchy, an established model in the field of medical education, was used (169). The assessment was made according to the information provided in the studies, which sometimes was very brief. Consequently, the full dimension of the respective curricula may not have been captured.

Finally, a note on the search procedure. A particular difficulty encountered in literature reviews covering aspects of medical education is that curricular interventions are not seldom published within the realms of grey literature. Thus, relevant articles may have been missed even though the search was extensive and performed with the aid of experienced librarians.

5.7 CONSIDERATIONS OF THE QUALITATIVE CONTENT ANALYSIS (STUDY IV)

For Study IV, qualitative content analysis (QCA) was used (170). The main reason for this was the nature of the research question, involving the informants' views on the VP-system in intercultural training. In other words, the purpose was not to generate a theoretical concept, but rather to collect descriptive data.

This section will focus on my understanding of QCA in relation to GT, highlighting what I understand are the main differences and similarities, the main difficulties encountered in the present study and how they were accounted for. QCA resembles the constructivist approach of GT in its fundamental ideas of data being contextual and that generating data involves co-operation between the researcher and the informants. So regardless of whether the analysis is of manifest or latent content, some degree of interpretation is always involved (149, 170).

5.7.1 Sampling and informants

The initial sampling purposively aimed to have residents as the main target group. Purposive sampling is a non-probability sampling procedure relying on the researcher's judgement to obtain relevant information (171). But as sampling is a stepwise procedure open to adjustment as the analysis progresses, changes to the inclusion criteria were made: thus when the early interviews indicated that the VP-cases might also be suitable for medical students on rotation in PC, the target group was widened to include them. Within the respective groups no further structured sampling was done, but instead convenience sampling (171) was applied, since there were difficulties in finding informants willing to set aside time for testing the VP-system. Even though convenience sampling is an established method, it was considered a limitation.

5.7.2 Data collection and analysis

Semi-structured interviews were conducted by the present author. As in GT, an author's position needs to be considered, weighing pros and cons. In this instance, the main issue was my involvement in developing the VP-cases. However, deep knowledge of the VP-system was deemed to outweigh the adverse aspects, which mainly concerned the risk of informants

omitting negative comments for reasons of social desirability. To compensate, they were also encouraged to criticize the system, emphasizing that it would guide improvements.

The process of data collection and analysis is iterative just as in GT, but the process of coding differs, a main difference being that in QCA one is coding for topics, whereas in GT actions are coded for (150, 170). The coding nomenclature also differs between QCA and GT, but this is beyond the present scope (170).

5.7.3 Trustworthiness

The use of concepts for describing trustworthiness in QCA differs from that in GT (discussed later in section 5.9). Credibility, dependability, and transferability are often linked to QCA (170). Though interrelated, they are often presented separately (170). Credibility deals with how well the data and process of analysis address the intended focus of the study (170). Here sampling is important, but also how data is interpreted. A way of increasing credibility, applied in this study, was by seeking agreement through 'member-checking' (170). Dependability deals with consistency in data over time (170). While interviewing is a process that must be allowed to evolve as new insights are acquired, there is a risk of inconsistency if data collection is extensive and protracted, and this was addressed through discussion within the research team. How far results can be transferred to another context is always the reader's decision, although it is the researcher's responsibility to facilitate this decision through transparency (170). This was done through outlining the context and characteristics of the informants, and accounting clearly for the process of analysis, e.g. by providing quotes.

5.8 GENERATING A CORE VARIABLE THEORY FOR THIS THESIS

The constant comparative method of GT was used for Studies I and III. However, the results are not claimed to be core variable theories, but rather conceptual models grounded in data; nonetheless with possible educational and clinical value.

For this thesis, however, an attempt at constructing a core variable theory has been made. Memos from Studies I-IV, together with theoretically sampled literature from related fields of knowledge and additional memos from presenting the results to clinicians and fellow researchers, have been incorporated to generate a tentative core variable theory. The original memos on categories from Studies I-IV were re-sorted together with new memos comparing concepts and incidents, in accordance with the constant comparative method. Additional memos were written and formed the basis for the theory presented in this thesis where 'overlooking health acculturation' emerged as the core.

Generating a core variable theory is a stepwise procedure, and this is reflected in the fact that Study I does not use health acculturation. At the time the paper was written, health acculturation was not a concept that had emerged, but as the analysis progressed, the term evolved and was found applicable. The conceptual models presented in Studies I and III are not to be viewed as fixed, but rather as momentaneous summaries. Nor does this thesis claim

to present a finished theory; as in GT, an openness to modify a concept or theory as new information emerges is a key feature.

5.9 CONSIDERATIONS OF THE GROUNDED THEORY: FIT, RELEVANCE, WORKABILITY, AND MODIFIABILITY

A GT is often assessed by the criteria of fit, relevance, workability, and modifiability (150, 163). These should be viewed as continuous rather than dichotomous entities: the generated theory is not classified as right or wrong, it just has more or less of each criterion.

Fit indicates how closely the concepts are related to the data, i.e. the incidents they represent. Fit was ensured, to the extent possible, by adhering throughout to the iterative process of constant comparison. As discussed previously, measures were also taken to account for differences in language, as changing language affects nuances of the content and consequently the fit.

Relevance deals with whether the informants' concern is reflected as it emerges from the data. The core variable theory presented in this thesis was constructed through a process which allowed for emergence and in which one consciously avoided data being forced into preconceived structures or ideas. This was reflected in the winding road of the research process as the theoretical concept in Study I did not reflect ideas of acculturation theory; further analysis was required for emergence.

The summary of the latent behaviors outlined by the core variable theory took variations in residents' behaviors into account. Further exploring the theory's workability, interviewing specialists in family medicine, would be of value.

As for modifiability, time will tell, as this is assessed by whether the theory can be adapted and developed when new relevant data is added.

5.10 REFLEXIVITY

Reflexivity refers to examining how the interests, positions and assumptions of the researcher may influence the research process, and the possible effect of this on the knowledge constructed (150). While this is a concept that is not part of classic GT, it is emphasized in the constructive approach, where the result (as discussed) is seen as a product of the interaction between researcher and informants (150). In the following paragraphs a discussion on my reflexive stance in relation to the subject matter is therefore summarized.

First, my background as a physician positions me in the microculture of medicine. Throughout my medical education, I was fostered in a biomedical environment where a positivist approach to knowledge was encouraged. I had no training in qualitative research, nor in the medical education field, until completing a short research project as part of residency training, which also sparked the interest to continue with research. Since being introduced to qualitative methodology my approach to knowledge has leaned towards a

constructivist approach which, as outlined previously, has been the framework for the present work.

Further, my clinical background as a specialist in family medicine brought familiarity with the study setting and its preconditions. This enabled theoretical sensitivity but also increased the risk of applying one's own preconceptions to the data. However, in terms of intercultural consultation, I would approximate my experience before the start of this project as average for a family medicine specialist working in Stockholm. I have worked at PC centers located mainly in the city and nearby suburbs where, at the time, migrants visited, although not particularly frequently.

In addition, being Swedish-born, I lack personal experience of migration and of intercultural consultation from a patient perspective. Therefore, I could not personally relate to the experience shared by the patient informants regarding this. While this meant a reduced risk of preconceived ideas about what the patients would report, differences between myself and the informants may also have introduced misinterpretations when analyzing the data.

Finally, it is important to acknowledge my involvement in the development of the VP-cases as this may unintentionally have caused a more positive interpretation of the data pertaining to Study IV.

The issues raised above were addressed throughout the project with various measures such as memo-writing and interprofessional group discussion in GT seminars and within the research group, involving members from various occupational backgrounds.

5.11 ETHICAL CONSIDERATIONS

The qualitative work presented in this thesis adheres to the ethical principles for medical research involving humans as outlined in the Declaration of Helsinki (172).

The systematic literature review (Study II) was conducted and reported according to PRISMA guidelines. According to best practice, the study was also registered in Prospero [registration number: CRD42018104819] prior to start.

5.11.1 Risks and benefits

For the informants participating in Studies I and III, the main risk was considered to be sharing sensitive information. To ensure that the informant was in no way identifiable, quotes selected to illustrate categories in the manuscripts were chosen with care and the informants were also given the option to read the manuscript prior to publication.

Participating in a study exploring views on a VP-system designed for learning purposes (Study IV), was not associated with any great risk of harm for the informants, since they also took part in clinical work. It was reasoned that exposure to a patient in a virtual environment is comparable to everyday clinical situations for both residents and students on clinical rotation. A suggested benefit is increased awareness and knowledge of the issues addressed.

5.11.2 Research involving groups at risk of disadvantage

When considering possible risks of the project, extra awareness was given to the population of patients included. Foreign-born individuals, whether they are refugees or have other migrant status, make up a heterogeneous group, also including individuals who would not necessarily view themselves as vulnerable. However, on a group level they are often considered at risk of disadvantage, which demands extra consideration in terms of planning and conducting research, as well as communicating the purpose (173).

Ethical guidelines state that if knowledge can be obtained by including a different population, research on vulnerable and disadvantaged populations should be avoided (174). However, in this case it was not conceivable, since it was the experience of this group that was of interest to fill the identified gap in knowledge. Moreover, including foreign-born patients is also in line with the notion that groups underrepresented in research should be granted appropriate access (172).

In addition, ethical guidelines state that the risk of participation should be minimized and that there should be a clear benefit for participating in research, especially for a disadvantaged group (174). A clear benefit was that the patients were enabled to share their views on the consultation as such, which under other circumstances would likely not be considered in detail. In the future, foreign-born patients will hopefully also benefit from an increased understanding of intercultural consultation.

Finally, the risk of adding negative stress or stigma to a vulnerable group also demands extra consideration of how the results are presented. This was catered for through a careful choice of wording and of the quotes included.

5.11.3 The use of interpreters

Although most informants were proficient in Swedish, interpreters were required occasionally, which then changed the preconditions for the interview, as the data then is co-constructed by three parties (175, 176). Moreover, dependence on the skill of the interpreter is unavoidable. However, to reduce the risk of misconstruction, the use of professional interpreters was consistent throughout the project and the transcribed interviews were checked by independent translators (175, 176). The informants' answers were sometimes shortened by the interpreter, but the translations were in general deemed accurate as the content did not change.

In addition, the issue of confidentiality being compromised also needed attention. The use of professional interpreters ensured, to the extent possible, an awareness of and compliance with their professional code of ethics, which includes confidentiality (177). This was emphasized at the beginning of each interview. Nonetheless, the informants may have altered what they chose to disclose. However, the option of excluding informants needing an interpreter was, ethically, considered an inferior option. A comparison between transcripts where interpreters were used and where they were not, did not indicate any weighted prevalence of negative or

positive statements, but no further linguistic analysis was performed since this is not usually part of GT.

5.11.4 Informed consent

All informants received written and verbal information on the purpose of the study, emphasizing confidentiality and the voluntary nature of participation, with the right to decline or withdraw their given consent at any time, without having to give reasons. The written information for the patients was translated and back-translated (178) by professional translators into their respective native languages. In the case of the informants also being patients, they were informed that their current or future need of care would in no way be influenced by their choice to participate. For Studies I, III and IV, informed consent was given in writing by each informant before the start of each interview.

5.11.5 Privacy and confidentiality

Health care staff working at the PC centers assisted in recruiting the informants by handing out written information on the study. However, all communication following the initial contact took place with the respective interviewer, neither of whom was involved in the care of the patient.

With the consent of each informant, the interviews were also audiotaped. The audio-files were stored separately in a locked cabinet (accessible to the main supervisor) after transcription. In addition, to ensure privacy and confidentiality, the transcripts were anonymized. Finally, the characteristics of the informants were presented on an aggregate level in the respective studies.

5.11.6 Research Ethics Committee

The research was approved by the Regional Ethical Review Board in Stockholm [ref: 2015/1228-31/5, 2016-2308-32 and 2020-01486].

6 RESULTS

This section will propose an overarching core variable theory generated for this thesis, with reference to applicable parts of the included Studies (I-IV). Hence the results of the studies will not be reiterated in full; instead a summary is provided in the following paragraph.

Studies I and III outlined conceptual models of different aspects of intercultural physician-patient interactions in PC consultations. They were labelled 'circling the undefined' and 'shifting patient perceptions of psychiatric diagnoses'. Both studies were based on a dual perspective, including physicians and patients. Therefore, the part of the core variable theory pertaining to the consultation, introduced below, incorporated this dual perspective as well. Study II outlined components of the informal curriculum in family medicine – cultural competence being one – and evaluated educational interventions attempting to formalize these. Study IV built on the previous studies by developing and evaluating VP-cases for intercultural training in a family medicine context, where results indicated they may be helpful in, for example, concretizing and reflecting on the concept.

6.1 OUTLINING THE CORE VARIABLE THEORY *OVERLOOKING HEALTH ACCULTURATION*

Using data from Study I-IV, and additional memos (as discussed in section 5.8), the core variable theory overlooking health acculturation was generated. The theory incorporates three main findings:

1) How acculturation takes place in a PC context in which the individual's external practice and internal domains, related to the concepts of health and illness, seem to be affected. It is therefore suggested that health may be an additional dimension to the concept of acculturation and hence the concept health acculturation is proposed. It is further outlined in section 6.2.

2) Health acculturation is being overlooked, both in the intercultural consultation in PC and in residency training. The dual meaning of 'overlooking' as in both failing to notice and pretending not to notice is incorporated in this theory as the analysis indicated the occurrence of both.

3) Although overlooked, residents are likely to take part in the patient's health acculturation process.

In terms of whose main concern is being dealt with, this was evaluated for the core variable theory from a resident perspective where the main concern was how to reduce the complexity of intercultural consultation. The behaviors described in Studies I and III, which I suggest affect the patient's health acculturation, are approaches seeking to solve this main concern. They might be effective in the short run by simplifying the consultation, but for gaining mutual understanding, they are likely less useful, and this was also briefly touched upon by

the residents. The core variable theory summing up these latent patterns of behaviors was labelled overlooking health acculturation. It is outlined below in section 6.3.

6.2 OUTLINING *HEALTH ACCULTURATION*

The concept of acculturation is well established in psychology and of increasing interest in public health, as discussed in the Background. Health has however, to the best of my knowledge, not been considered a dimension of acculturation; rather, it has been discussed as an outcome. This thesis argues that health should be considered an additional dimension; and therefore proposes a new concept: health acculturation.

Health acculturation is suggested to describe changes in an individual's external practices and internal domains, related to health and illness, when being exposed to another culture. In keeping with symbolic interactionism, these changes emerge and are modified through interaction and interpretation, where the consultation in PC may play a substantial part. In the present work the context is restricted to Swedish PC.

In line with how the WHO's definition of health incorporates 'disease or infirmity', or rather the lack of it, in order to achieve health (179), health acculturation also includes views on illness as the two are regarded as interrelated. In addition, I emphasize the subjectivity of the concept, as notions about what health incorporates are cultural (38).

In accordance with existing theories of acculturation, discussed in the Background, the concept of health acculturation subsumes an external component, reflecting changes in practices and behaviors, and an internal component, reflecting changes in feelings and attitudes. These are discussed below in sections 6.3.1 – 6.3.2.

6.3 OVERLOOKING HEALTH ACCULTURATION IN THE CONSULTATION

Here, 'overlooking health acculturation in the consultation' is outlined by first examining what changes during health acculturation (external and internal components), and then suggesting how this might come about through the physician-patient interaction in the consultation. These components reflect two of the three main components of Berry's theory of acculturation, which in addition to 'what' and 'how' also incorporates a third variable: how well an individual has adapted to acculturation. The latter is not evaluated in this thesis.

6.3.1 Outlining the external component of health acculturation (Study I)

The external component of health acculturation refers in this thesis to what takes place in the intercultural consultation in terms of practices and behaviors.

Study I did not discuss health acculturation. Instead, the conceptual model presented was labelled 'circling the undefined'. As discussed previously, this is an example of how allowing for emergence is part of how a theory is developed in GT: as the analysis progressed the findings were reinterpreted in terms of acculturation theory.

‘Circling the undefined’ referred to how a shared understanding of adequate practices and behaviors in the consultation was assumed, by both the patients and the residents, and therefore not considered or discussed. The behaviors outlined in Study I seemed to circle or avoid, rather than address, these issues. In other words, the external component of health acculturation was overlooked. Instead the term culture was used as a black-box explanation for behaviors not understood or deemed inadequate, as outlined in the category labelled ‘culture blaming and explaining’.

Meanwhile, data from the interviews showed that views on what was deemed as adequate practice or behavior varied, not only between and within groups, but also over time for the individual patient, the latter in line with theories of acculturation. Examples outlined in Study I were changing views on patient-physician responsibilities, what the role of the physician involved, and what was considered ‘intrusive’ to discuss.

6.3.2 Outlining the internal component of health acculturation (Study III)

Internal acculturation in general refers to changes in ‘attitudes, preferences and feelings’ (101). Accordingly, the use of internal health acculturation in this thesis refers to changes in attitudes and feelings in relation to health and illness. To clarify, when writing about changes taking place internally, this is of course merely a reflection of how these changes have been disclosed by the informants. This issue is wrestled with in general in studies on emotional acculturation (103).

Study I broached the subject of how differing views on the concepts of health and illness could be a potential source of confusion. This line of thought was further explored in Study III, with focus on cultural aspects of emotional distress, which suggested a shift taking place in patient perceptions of psychiatric diagnoses, from their rejection to acceptance as culturally valid models to explain suffering.

This shift in patient perceptions was described by the interviewed residents and patients alike. A feeling of dismissal and/or distrust was pronounced by the patients as a common initial reaction to receiving a psychiatric diagnosis. It was also often associated with stigma. With time the patients described how these feelings could fade in favor of growing acceptance.

6.3.3 How health acculturation may be facilitated in the consultation (Studies I and III)

The terms ‘getting used to’, or ‘learning’, or even ‘process of integration’ were used by the informants when describing how changes in the patients, as described above, might occur or be facilitated. Accordingly, the analysis of the interviews also involved trying to identify what specifics in the consultation might contribute to this process of ‘learning’ or ‘integration’, which could also be interpreted as a process of acculturation.

In summary, the residents were likely to take part in health acculturation through various behaviors in the consultation, although not intentionally, hence the term ‘overlooking’. In Study I the category ‘fitting the box’ was described as a way of indirectly demonstrating what

is accepted in a specific cultural context, using diagnostic manuals and guidelines as points of reference. In Study III, three different approaches were identified – biomedical, didactic, and compensatory – which all inadvertently signaled that, in the present cultural context, psychiatric diagnoses are valid explanatory models of distress. Using the word 'approach' here indicates more of an intentional action, whereas behaviors are understood more in the line of reflexive activities.

While some concerns were raised by the residents regarding, for example, how the patient might perceive certain diagnoses, their own possible influence on the patient's perception of psychiatric diagnoses in a wider sense seemed to be overlooked.

6.4 OVERLOOKING ACCULTURATION IN RESIDENCY TRAINING

The concept of acculturation, as well as culture in general, also seemed to be overlooked in residency training. The findings of the literature review (Study II) and the interviews conducted with the residents (Studies I, III and IV) pointed in the same direction: acculturation and related concepts are overlooked by the formal curriculum and at best cultural competence is gained informally.

The term cultural competence is, as previously mentioned, to date probably the most established in medical education. While recognizing its limitations it will therefore be used in the following sections.

6.4.1 According to findings in the literature (Study II)

The systematic literature review in Study II outlined how 'gaining cultural competence' is part of the informal curriculum for residents, together with 'achieving professionalism' and 'dealing with uncertainty'. The literature suggested that the informal curriculum is probably partly contextual. Whereas 'achieving professionalism' seemed to recur as a theme of the informal curriculum across specialties, 'dealing with uncertainty' and 'gaining cultural competence' seemed more limited to the informal curriculum of family medicine.

Study II also explored how the themes of the informal curriculum were transferred i.e. informal learning. Even though exposure to cultural diversity was considered an important way of learning, risks were also identified; such as being over-reliant on individual patient encounters triggering learning and the supervisor's competence.

The term acculturation was not included in the original search string, again as the analysis had not reached the stage where this term had been identified as part of the core variable theory. However, analyzing the included articles when generating the theory, as well as performing additional literature searches including 'acculturation', have not generated any findings indicating that it is a term considered in formalized intercultural training for residents.

In addition, the existing curriculum for residents in Sweden does not mention culture or acculturation. The term 'ethnicity' is used in the context of 'treating the patient as an

individual and with respect regardless of […] ethnicity' (author's translation) (63). Ethnicity should however not be viewed as a proxy for culture, as discussed previously.

6.4.2 According to the experience of residents (Studies I, III and IV)

The residents' accounts of the intercultural training they had received so far described a general feeling that it had been more or less absent. What they had been formally taught seemed mainly in line with the 'positivist approach', whereas thoughts reflecting the 'social constructionist approach' or the concept of acculturation, seemed to have been scarce. Moreover, the residents described an unequal access to intercultural training, being dependent on the population listed at the PC center and their supervisor's knowledge. In addition, cultural competence was viewed as an abstract concept; how to apply it in the consultation was not evident.

The VP-system evaluated in Study IV may serve as a starting point for addressing these issues, since the VP-cases were designed to visualize intercultural consultations – specifically meeting patients with refugee backgrounds. The study sought to explore a learner perspective on the educational use of a VP-system designed to contribute to intercultural training in a PC context. The VP-system tested was viewed as a means to even out existing preconditions and to concretize cultural competence through case-based training anchored in PC. It was also welcomed by the informants as an incentive for discussion and reflection, the latter enhanced by the built-in feedback system.

7 DISCUSSION

7.1 SUMMARY OF MAIN FINDINGS

The studies included in this thesis are to my knowledge a first attempt to use GT to outline what happens in the physician-patient interaction in intercultural consultations in Swedish PC. 'Overlooking health acculturation' emerged at the core, with health acculturation being a concept introduced in this thesis. Below (section 7.2), the 'what' and 'how' of this concept will be discussed in relation to 'explanatory models of illness', theories of acculturation, polyculturalism and learning.

This thesis also argues that the overlooking of health acculturation in the consultation mirrors how the general concept of acculturation is overlooked in residency training, where knowledge is also gained mainly through informal learning. Implications are discussed below, in section 7.3.

7.2 HEALTH ACCULTURATION IN PRIMARY CARE CONSULTATION

Health acculturation, it is proposed, incorporates changes in the individual's external practices and internal domains related to health and illness, when exposed to another culture; in this case the contemporary microculture of Swedish PC. The process seems to be influenced by the physician-patient interaction in the consultation. Influences from other contexts are likely to contribute as well, such as interactions with friends and family and society at large. Exploring this is outside the scope of the present work, so my argument will focus on physician-patient interaction. The following sections discuss the 'what' and the 'how' of health acculturation, in relation to previously published literature.

7.2.1 The 'what' of health acculturation

The 'what' of health acculturation is here discussed in relation to ideas stemming from 'explanatory models of illness' and emotional acculturation.

Kleinman's 'explanatory model of illness' illustrates how individuals conceptualize illness (180). It includes the individual's perspective on probable cause, mechanisms of disease and ideas on appropriate treatment (180). The model is, in addition to culture, influenced by other qualities such as level of education, age, gender and previous experience (180).

The basic assumptions of the concept – that beliefs about illness vary between individuals, are partly informed by culture, and are subject to possible change – are in line with the suggested concept of health acculturation. However, health acculturation may add to understanding the complexity of intercultural consultations by incorporating other dimensions as well. While the concept of 'explanatory models' pertains largely to ideas of the illness per se, I suggest health acculturation is a broader concept, incorporating ideas on the physician-patient interaction as well as internal experience connected to illness.

The concept of emotional acculturation suggests, as outlined in the Background, that internal experience, or patterns of emotions, can change as part of acculturation (99). This is in line with the results presented in Study III on shifting patient perspectives on emotional distress. Research on emotional acculturation has also indicated that the same emotion seems to be experienced differently across cultures and that the associated feelings can change as part of acculturation (99, 100). When exploring the emotion of anger, it has been suggested that in cultures valuing interdependence, anger is associated with a feeling of guilt; while in cultures emphasizing independence, anger is rather associated with a feeling of being in control (99, 104). Sadness or suffering is also one of the ´basic emotions´, which may typically be associated with a feeling of grief. However, referring to Study III, one may also ask whether exposure to a microculture 'favoring' diagnoses as explanatory models could direct these associations towards a feeling of depression? Some have even suggested that on a macro-level in Sweden, there is a current tendency to suffer in a 'biomedical way' (181).

7.2.2 The 'how' of health acculturation

As mentioned in the Background, implicit learning processes, such as social learning theory, seem to be of significance when exploring acculturation in terms of learning (72, 95, 100). As I understand it, this is also reflected in polyculturalism, where intercultural interactions are viewed as determinants of culture (72). Polyculturalism and the acquisition of 'cultural schemas' are discussed below as I believe these ideas may be helpful in addressing the 'how' of health acculturation in the future. First, however, a comment on possible influences on how health acculturation is facilitated in the consultation today.

Returning to Kleinman's concept of 'explanatory models'; the physician-patient interaction is central, 'teaching' being part of that process (180). This seems well anchored in contemporary consultations, as reflected in the results (Studies I and III). According to Kleinman, a successful consultation involves eliciting the patient's model and identifying where it differs from the physician's (180). If necessary, the patient's model could also be 'adjusted', to align with the physician's, through for example patient education (180). The idea of aligning explanatory models is reflected in two of the approaches of the residents, described in Study III as the 'biomedical' and the 'didactic' approach, through which the residents also inadvertently demonstrate 'culturally acceptable' ways of expressing illness. This is how, I suggest, they also take part in the patient's health acculturation process.

Although the concept of 'explanatory models' is useful in many aspects, it may also carry an assumption that aligning the explanatory models allows a fixed goal to be reached. This idea of a finite outcome is also reflected in the traditional acculturation theory of Berry, with the outlining of four possible outcomes as discussed previously (1). Current research, however, focuses on a more dynamic and pluralistic view, one example being the idea of polyculturalism (72).

Polyculturalism captures the idea of individuals engaging with elements both from their primary culture and from other cultures, acquiring various frameworks that can be more or

less active depending on circumstances (72). It is a shift from the paradigm of culturalism, which views cultures of the world as separate and independent – to include a dynamic and constructivist view, as reflected in the idea of gaining and activating 'cultural schemas' (182).

A model outlining the idea of how cultural schemas may be acquired is the prediction-observation match-mismatch model (183). This outlines how contextual cues for each situation activate relevant cultural schemas, which involve expectations and predictions about how the situation is likely to unfold. The cultural schema is strengthened, and later likely to be re-activated, if the situation unfolds as predicted and the individual experiences cultural fluency. Conversely it is weakened if not. Experiencing cultural disfluency, which occurs when the situation unfolds unpredictably, will then lead the individual to seek new information on how to act next time (183). It is also suggested that in early stages of acculturation there is a tendency to chronic repetition of a 'mismatch loop' where 'cultural disfluency' continues, maybe due to inadequate information or because encountering an unpredictable situation may not be the same as registering it (95, 183). The conceptual model of 'circling the undefined' (Study I), outlining how external aspects of health acculturation are being overlooked, seems to fit this model. When a 'mismatch' occurs, in e.g. patient expectations on the physician's role, it is not likely to be addressed, i.e. no new information is added. This allows for repeated misunderstanding – a repeat of the 'mismatch loop'. The physicians' overlooking of their part in the patient's acculturation process may be one reason why they neglect to address this, hence neglecting to facilitate leaving the 'mismatch loop'.

7.3 SUGGESTED IMPLICATIONS FOR POLICY AND PRACTICE IN RESIDENCY TRAINING

This thesis argues that health acculturation should be considered in intercultural consultations. However, excluding culture from the curriculum for residents in Sweden in favor of concepts such as ethnicity (63) communicates that culture is irrelevant and reinforces the idea of the interchangeability of 'ethnicity' and 'culture'. Even though more than 20 years have passed since a comprehensive policy document from the Swedish National Board of Health and Welfare proposed introducing cultural competence in medical schools (184), it still seems to be treated in a cursory manner since the residents interviewed have trouble recollecting what (if anything) they have been taught here. Nor have I found any publication formally evaluating the outcome of the proposition.

In resident training, informal learning in the workplace is, as mentioned, highly prevalent. This is not necessarily problematic when it comes to intercultural training, as exposure to diversity is important for learning (128). There are, however, prerequisites for this to be valid, such as a basic level of pre-existing knowledge (185) and access to adequate support from supervisors (83). In addition, there are three other issues I suggest should be addressed in order to improve intercultural training for residents in the current context: discuss and disclose the informal curriculum, apply already existing knowledge on informal learning in practice and add contemporary perspectives on culture. These are discussed in the following sections.

7.3.1 Discuss and disclose the informal curriculum

There is general agreement on the significance of the informal curriculum in medical education: its existence is no longer controversial (186-189). Although the nature of the concept makes it elusive, there is discussion on whether it is useful to identify its components (189, 190). I believe it is useful, since it is likely to reflect contextual 'common knowledge', and the risk of knowledge gaps is evident if one does not recognize its components. Study II outlined a suggestion of what the informal curriculum of family medicine entailed according to literature: in addition to cultural competence, medical professionalism and dealing with uncertainty were identified. These aspects are all highly relevant to be mastered during residency. Considering that knowledge is more likely to be retained if learning goals are formulated (191), acknowledging what is actually taught informally may be a first step to improve training in these areas.

7.3.2 Apply existing knowledge on informal learning

The literature on informal learning in residency is scarce, but a knowledge base has been formed in contemporary research on workplace learning, which may be relevant for residency training as well (113, 191, 192). Ideas on how the individual's intention to learn is associated with knowledge retention are of interest. Various types of informal learning illustrating this have been outlined: reactive and deliberative are two examples (192).

Deliberative informal learning is associated with higher knowledge retention: here the intention to learn is clearly pronounced and it involves active discussion and reflection on past experience when engaging in problem solving (192). The residents interviewed (Studies I, III and IV), however, described situations more in line with reactive types of learning when discussing intercultural training, i.e. the primary purpose was to manage work while hopefully learning something along the way. A feature of reactive learning as described in the literature is that there is an intention to learn, but the given situation provides little time to think, so drawing on previous experience for example occurs almost spontaneously (192). Work pressure has also been mentioned as a risk of tilting the balance for residents between learning and delivering patient care (113).

Since improved intercultural training has been called for, and informal learning is likely to dominate resident training in the future as well, applying existing knowledge from workplace learning to a greater extent is one way forward. It has been suggested that informal learning could be exploited more effectively if complemented with planned learning situations (191). This may provide a better opportunity to integrate practical experience and skills with conceptual knowledge, facilitating the development of competence (191).

Since learning through planned activities is likely to increase knowledge retention (192), easy access to educational tools in the workplace, such as VPs, would also be beneficial as it may encourage deliberative informal learning. It may also decrease over-reliance on the supervisor, which was a concern expressed by the residents interviewed (Study IV), as well as in the literature (83, 128). Stimulating reflection and discussion is an important feature of

any tool aiding informal learning, and the VP-system evaluated in Study IV was also considered by the informants to accommodate this.

7.3.3 Add contemporary perspectives on culture

Finally, I would suggest introducing into medical education contemporary perspectives on culture, such as polyculturalism and the concept of health acculturation outlined in this thesis, since if what is taught is out of touch with current views, arguing its relevance is difficult.

Culture as a concept has evolved historically; nonetheless its previous use still has bearing on the way it is sometimes interpreted today. In my opinion, recognizing this and updating what is taught is a key in intercultural training for residents. For example, as discussed, the use of the 'positivist approach' may risk endorsing an outdated idea of culture as something static, signifying the individual's belonging to a certain group. By instead applying a polyculturalist framework, which is more in line with how the world of today is shaped – migration and intercultural exchange being widespread – the understanding of culture as something fluid and unique to everyone could be promoted.

Moreover, by not actively abandoning the view of culture as something 'belonging to others', one's own part is easily overlooked. One central aspect of health acculturation stresses that the physician does play a key role in influencing this process in the patient. If this is recognized, residents may also consider intercultural training more relevant.

7.4 IMPLICATIONS FOR RESEARCH

This thesis contributes to the understanding of why intercultural consultations in PC settings are often perceived as complex and suggests health acculturation as a concept that could be considered in future intercultural training.

However, to further delimit the concept of health acculturation, studies in other PC settings also including informants that are specialists are recommended. Moreover, repeat interviews with individual patients over a longer period, following their contacts with physicians in PC, may afford a possibility to identify key aspects of the interpersonal interaction in the consultation that contribute to the process of health acculturation. Observations of consultations may also be of value.

In addition, physicians with a migrant background constitute a large part of the PC work force in Sweden but are, on a group-level, probably underused as sources of information. Residents born and trained abroad were included in Studies I and III but a focused exploration of their dual and flipped perspectives was not within the framework of this work. Nonetheless, it would be an area of interest for future research.

On that note, physicians trained abroad likely have various experiences of consultation training in general. Formal consultation training may be lacking and even though patient centering is strongly advocated in Sweden, this may not be the case worldwide. Exploring different styles of communications in intercultural consultation would be of interest, as would

examining whether previous general consultation training has any effect on how intercultural issues are addressed.

Moreover, research is still needed regarding educational interventions to improve intercultural training for residents. VPs as educational tools may, as mentioned, contribute to learning taking place informally, as they were seen to stimulate reflection and discussion and reduce supervisor dependence. However, before implementing them on a larger scale in residency training, exploring their use within various learning activities is suggested.

Finally, one may assume that increased knowledge and understanding of culture and associated terms would benefit patients, though this has to date been difficult to show. Ideally, future studies would nonetheless aim to examine the effect of an educational intervention on patient-related outcomes such as compliance or access to health care. Preferably this would take place in a primary care setting.

8 CONCLUSIONS

Intercultural consultations are complex, partly because some of the behaviors and approaches applied tend not to facilitate mutual understanding. This thesis argues that these behaviors and approaches, summed up as ‘overlooking health acculturation’, mirror that acculturation and related concepts have been overlooked in residential training.

An outdated idea of culture still seems to permeate what is taught in medical education. Meanwhile, related fields of knowledge have incorporated more contemporary views, such as the idea of acculturation, which has evolved in the field of psychology. Based on the present results, acculturation would be well worth considering in the context of primary care, where practices and attitudes related to health and illness may partly be shaped by the interaction in intercultural consultations, a concept introduced in this thesis as health acculturation.

Intercultural training for residents is likely to continue through informal learning to a great extent, this being in line with the nature of residency training in general. In addition to applying more contemporary views on culture, improvements could also be made by introducing easily accessible educational tools, such as virtual patient cases, to stimulate reflection and discussion on a topic that is present in everyday work but at the same time deeply overlooked.

9 POPULÄRVETENSKAPLIG SAMMANFATTNING (POPULAR SCIENCE SUMMARY IN SWEDISH)

Konsultationen beskrivs ofta som allmänläkarens viktigaste verktyg, dels för att ställa diagnos, dels för att skapa allians med patienten. Samtidigt upplevs patient-läkarmötet mellan individer från olika kulturer ofta som komplicerat; ’kulturella skillnader’ brukar anges som en bidragande orsak. Detta bör adresseras med tanke på att primärvården ska kunna erbjuda ett växande antal patienter, med varierande kulturell bakgrund, vård på jämlika villkor – en grundläggande princip i den svenska hälso- och sjukvårdslagen.

Ett sätt att ta sig an den ojämlikhet i hälsa och vård, som trots allt föreligger, är att öka kunskapen hos läkare i interkulturella konsultationer. När det gäller utbildning för ST-läkare i allmänmedicin i dessa frågor finns det dock inga tydliga riktlinjer för hur den bäst ska ske. Därför var syftet med studierna, som ligger till grund för avhandlingen, att utforska mötet mellan ST-läkare och patient i interkulturella konsultationer, samt att därefter undersöka hur resultaten skulle kunna användas i utbildningssyfte. Forskningen förankrades i svensk primärvårdskontext.

I avhandlingen presenteras en modell som delvis kan förklara varför den interkulturella konsultationen i primärvården kan upplevas som komplicerad. Sammanfattningsvis illustrerar modellen hur man i konsultationen förbiser att patienten över tid verkar genomgå en ackulturationsprocess gällande frågor som rör hälsa och sjukdom. Ackulturation är ett vedertaget begrepp som innefattar de förändringar i beteenden och tankemönster som sker när en individ exponeras för en ny kultur. Hälsa har diskuterats som ett mått på ’hur väl’ en person har ackulturerats. Avhandlingen argumenterar för att hälsa också bör tydliggöras som en *dimension* av ackulturation, eftersom beteenden och tankemönster relaterade till hälsa och sjukdom, samt till aspekter av patient-läkarmötet, verkar förändras och delvis påverkas av det som sker i konsultationen. ’Hälso-ackulturation’ föreslås som ett sammanfattande begrepp.

Förklaringsmodellen bygger bland annat på de fyra delstudier som ingår i avhandlingen. I två av dessa intervjuades ST-läkare i allmänmedicin och utrikesfödda patienter om sina upplevelser av interkulturella konsultationer i primärvård. Resultaten visade att bägge parter förutsatte en samsyn i vissa centrala aspekter av konsultationen, trots att den inte alltid existerade; exempelvis i syn på sjukdom och i uppfattning om ansvarsfördelning mellan patient och läkare. Resultaten antydde också att patienterna över tid verkade ’integreras in i’ rådande normer. Beteenden hos läkaren som skulle kunna påverka den här ackulturationsprocessen, om än inte nödvändigtvis på ett medvetet plan, identifierades.

Avhandlingen diskuterar även att kultur och relaterade begrepp som ackulturation verkar ha förbisetts i den formella utbildningen för läkare. I den mån de har belysts, verkar det ha funnits en tendens till att förmedla en syn på kulturbegreppet som kanske inte är helt linje med aktuell forskning. Därmed finns också en risk att man förstärker ett förhållningssätt till kultur som något som ’den andra’ personen besitter, man underskattar dynamiken och

därmed också sin egen påverkan. I det här fallet, sin påverkan som läkare på patientens ’hälso-ackulturationsprocess’.

Från forskningslitteraturen som sammanställdes i en av delstudierna, samt från ytterligare intervjuer med ST-läkare i allmänmedicin, framkom det att de i stor utsträckning förväntas förvärva kunskaper om interkulturella konsultationer genom, så kallat, informellt lärande. Det innebär att kunskap erhålls från kollegor på vårdcentralen och genom upplevda erfarenheter. Det kräver dock att rätt förutsättningar finns på arbetsplatsen, men så var inte alltid fallet. Bristande kunskap hos handledare uppgavs till exempel som ett hinder.

För att kunna erbjuda en möjlighet för ST-läkare att få tillgång till en grundläggande utbildning i interkulturella frågor, oavsett arbetsplats, togs det fram ett webbaserat utbildningsverktyg i form av interaktiva patientfall. Utvärderingen som presenteras i den avslutande studien visade att det kunde intiera reflektion och skapa diskussion, bägge är viktiga delar i informellt lärande.

Sammanfattningsvis så bidrar den här avhandlingen med ett försök att delvis förklara den upplevda komplexiteten i interkulturella konsultationer utifrån en modell förankrad i svensk primärvård. Den bidrar också med förslag på hur interkulturell utbildning för ST-läkare i allmänmedicin skulle kunna förnyas, inte minst rekommenderas att aktuell forskning får medverka med en uppdaterad syn på kulturrelaterade begrepp. Förhoppningsvis kan arbetet på sikt även förbättra förutsättningarna för ST-läkarna i primärvården att kunna ge vård på lika villkor.

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