How culture influences patient preferences for patient-centered care with their doctors

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How culture influences patient preferences for patient-centered care with their doctors

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Biographical notes:

Nicola Sheeran’s research interests include communication in health contexts, the role of culture in patient preferences for health communication, and interpreter use.

Professor Liz Jones’ research interests are an intergroup approach to health and organizational communication, and its impact on the quality of patient care, including health practitioner-patient communication.

Rachyl Pines conducts research in behavioral health, population health, and intergroup communication to improve patient-provider interactions and patient education.

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Aron Pamoso is interested in culture and social identities in shaping stigma and discrimination and its effects on mental health and well-being.

Jessica Eigeland’s research interests are in health communication, with a specific focus on the working relationship between health practitioners and patients and its impact on patient outcomes.

Maria Benedettiti is an Emergency Department nurse with over 10 years’ experience and a master’s in nursing leadership and education. Maria is interested in the role of culture in understanding why patients do not advocate for themselves or ask questions regarding medical care.
Declarations and ethics statements:

Ethical approval: Ethical approval was obtained from Griffith University (Ethics No 2019/972) on the 29th November 2019 and University of California, Santa Barbara Institutional Review Board (No 82-20-0104) on the 7 February 2020.

Informed consent from participants: Participants provided informed consent prior to completing the survey.

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Abstract

Background: Patient-centered care (PCC) is the prevailing model of care globally. However, most research on PCC has been conducted in Westernized countries or has focused on only two facets of PCC: decision-making and information exchange. Our study examined how culture influences patients’ preferences for different facets of PCC, including communication, decision-making, empathy, individualized focus, and relationship.

Methods: Participants (N = 2071) from Hong Kong, the Philippines, Australia, and the USA completed an online survey assessing their preferences for medical care that involved exchange of information, autonomy in decision-making, expression and validation of their emotions, a focus on them as an individual, and fostered the relationship between themselves and the doctor.

Results: We found similarities between countries on their preferences for empathy and shared decision-making. For other facets of PCC, participants in the Philippines and Australia expressed somewhat similar preferences, as did those in the USA and Hong Kong, challenging East-West stereotypes. Participants in the Philippines placed greater value on relationships, and those in Australia valued more autonomy. Participants in Hong Kong more commonly preferred doctor-directed care, with less importance placed on the relationship. Responses from USA participants were surprising, as they placed the least importance on the need for individualized care and two-way flow of information.

Conclusions: Empathy, information exchange, and shared decision-making are valued across countries, while preferences for how the information is shared, and the importance of the relationship differ.

Keywords: Patient Preference; Empathy; Decision-making; Communication; Emotions
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Patient-centered care (PCC) was developed in response to the limitations of traditional biomedical and paternalistic models of healthcare and is now the primary model of care in many countries. PCC takes a holistic view of patients, seeing them as unique human beings with values, needs, and preferences that must be integrated into care (Eklund et al, 2019). PCC in Western countries is associated with positive patient outcomes, including patient satisfaction, treatment compliance, improved clinical outcomes, and enhanced prevention (Stacey et al, 2014). However, evidence demonstrating the benefit of PCC for non-Western patients is lacking. Despite this, PCC is being taken up globally (Moore, 2008; Setlhare et al., 2014).

There is ongoing debate about how PCC should be defined, with recent reviews suggesting up to nine different facets (Eklund et al., 2019). Further, terms such as PCC, person-centered care, and patient-centered communication overlap and are used interchangeably. We argue patient-centered and person-centered approaches are similar but may place a subtle emphasis on a functional versus meaningful life (Eklund et al., 2019), and communication is essential in actualizing PCC (Street, 2019). Regardless, most authors agree PCC comprises a therapeutic relationship between the doctor and patient, shared decision-making, communication that is a two-way exchange of information, and an individualized and holistic focus that considers patients’ perspectives/preferences (Eklund et al., 2019; Langberg et al., 2019; McCormack et al., 2011). Empathy and ensuring that emotions are expressed and explored also feature in some models (Eklund et al., 2019; McCormack et al., 2011). Newer PCC conceptualizations include coordinated care (Eklund et al., 2019; Langberg et al., 2019). To date, most research on PCC across cultures has focused on two facets: shared decision-making and information exchange.
In Western countries, PCC is considered a collaborative or reciprocal relationship between doctor and patient, where power is shared and both parties work towards shared goals, with patients participating in decision-making (Stewart, 2001). However, patients’ preferences for collaboration and decision-making vary based on psychological factors (e.g., need for control, uncertainty tolerance; Johnson, 2011), individual difference factors (e.g., type, length and/or severity of disease or health literacy; Edwards et al., 2009), demographic factors (e.g., age, education, gender, and socioeconomic status; Arora et al., 2000; Cullati et al, 2011), and cultural factors (e.g., cultural values; Dolan et al., 2019). Thus, perceiving PCC as synonymous with a collaborative, equal, participatory relationship potentially undermines the principles of PCC, where individual needs, values, and preferences are considered.

A limitation of PCC research is that it has primarily been conducted in Western countries, with insufficient attention to how culture may influence patient preferences for how PCC is enacted (Charles et al., 2006; Sethlare et al., 2014). Research has predominantly focused on preferences for involvement in healthcare within a single country or region, with limited cross-cultural research investigating differences in patient preferences. However, previous research has documented some cultural differences in preferences for involvement in medical decisions (Alden, et al., 2018; Alden et al., 2015; Dolan et al., 2019; Fredriksson et al., 2017). For example, Fredriksson et al (2017) found small country differences for preferences for involvement in healthcare decisions in Sweden and England. More people in Sweden wanted the doctor to make decisions than in England and more people in England wanted to make their own decisions and not rely on a doctor than in Sweden. Thus, preferences for involvement in decision-making may vary by country, possibly due to norms or cultural values.

Some studies have examined cultural antecedents (e.g., individual-level cultural values of interdependence, independence, and power distance) as predictors of preferences.
for decision-making and information exchange. For example, interdependence predicted a stronger desire for influence in Japanese and American samples (Alden et al., 2015), but this effect was significantly stronger in Japan. The relationship between independence and desire for decision-making influence was significant only in the USA, and power distance negatively predicted desire for decision-making influence only in the USA. A similar study found interdependence, independence, and health locus of control predicted the desire for medical information in Australia and China (Dolan et al., 2019), but desire for involvement in decisions was only predicted by power distance. Other studies state broad cultural differences in PCC, for example around end of life management (Koenig & Gates-Williams, 1995) or did not statistically examine mean differences identified (Alden, et al., 2018).

This emergent literature has led to preliminary conceptual frameworks (Brown et al., 2016; Hawley & Morris, 2017) and decision aids (Alden, et al., 2018; Alden et al., 2014; Brown et al., 2016; Jull et al., 2015) that consider the role of race/ethnicity and culture in healthcare utilization. However, we maintain more foundational empirical work is needed. We argue for consideration of multiple facets of PCC, as research has primarily focused on decision-making and information exchange. Thus, our study examined how culture influences patients’ preferences for five facets of PCC: communication, decision-making, empathy, individualized focus, and relationship. Our study encompassed participants from four countries that differ in their cultural values and healthcare systems. We recognize culture as "the distinctive way of life of the group, race, class, community or nation to which the individual belongs." (O'Hagan, 2001, p. 228). We examined culture at the level of nation, in part, because countries have distinctive healthcare systems that likely shape patients’ expectations and preferences, in addition to shared national values.

Method

Participants and Procedure
Participants (N = 2071) residing in Australia, USA, Philippines, and Hong Kong were recruited into the study. Fifty-four participants recruited in Hong Kong resided in Mainland China\(^1\) but worked or studied in Hong Kong and were included in the Hong Kong sample. Thirty-six participants were identified as residing outside the countries of interest and were excluded. A further 446 were removed from the sample due to incomplete survey responses, multiple survey responses per participant (USA MTurk cohort), or response bias. The final sample comprised 1641 participants. See Table 1 for demographic information for participants from each country.

A convenience sample of participants was recruited using Amazon Mechanical Turk (Mturk) in the USA, and email and/or social media (i.e., Facebook) in Australia, Hong Kong, and the Philippines. Emails were sent via broadcast emails/group emails to university faculty and alumni, who then disseminated the invitation to participate through their networks. The study link was also disseminated through social media networks (i.e., personal, university, organizations/groups posts on Facebook). Mturk participants received $2, participants in Philippines and Australia could enter a prize draw to win gift vouchers, and those in Hong Kong received a coffee voucher. Students studying in each of the four countries were recruited through research participation systems run by each university and received course credit or a coffee voucher for participation. Participants in each country completed an online survey (hosted on Limesurvey) taking approximately 20 minutes (see supplemental materials). The survey was translated into Tagalog and Cantonese using a professionally qualified translation service and checked for accuracy and meaning by the multilingual members of the research team. Participants chose which language to complete the survey in.

**Materials**

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\(^1\) Countries included reflect the outcomes from the joint Asian Association of Social Psychology and International Association of Language and Social Psychology small group meeting that sought to bring together researchers from different countries to design studies to explore how communication dynamics influence healthcare across cultures.
In line with recommendations to map measures to the conceptual facets of PCC (Street, 2019), we selected measures reflecting five facets of PCC (communication, decision-making, empathy, individualized focus, and relationship). We drew on contemporary communication theories, such as Communication Accommodation Theory (CAT) and patient-centered communication (McCormack et al; Reeve, 2017), to guide our choice of measures and to provide a broader definition of communication.

**Patient-Centered Communication**

The Patient-centered Communication (PCC) survey developed by Reeve et al. (2017) is a 36-item measure designed to assess six patient-centered communication domains. The current study administered four of the six subscales: exchanging information (6 items, measuring communication), fostering healing relationships (7 items, measuring the relationship domain), responding to emotions (6 items, measuring the empathy domain), and enabling patient self-management (6 items, measuring individualized, holistic care domain). Participants rated each item's importance on a five-point Likert scale ranging from not important at all to extremely important. Each subscale had good internal consistency in the original research, ranging from .92 (fostering healing relationships) to .96 (responding to emotions). Cronbach’s α in the current study ranged from .80 (fostering healing relationships) to .92 (responding to emotions).

**Communication Accommodation Theory Strategies**

Preferences for doctor communication strategies were measured using 13 items from Watson and Gallois’ (1998) CAT strategies in health communication measure. CAT is an intergroup theory of communication that considers how group identities and status (i.e., doctor and patient) shape communication. The measure assesses the patient’s preferences for

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2 We did not include direct measures of coordinated care as our context was general health and not specific illnesses, where coordination would likely be important.
three communication strategies doctors use to accommodate (or not) to their patients: emotional expression, discourse management, and interpersonal control. However, reliability of the latter two scales in the current study was poor ($\alpha's = .39$ and .52). Factor analysis suggested a 3-factor solution still provided best fit, with items grouped into the strategies of emotional expression, Dr directs (non-accommodative communication where the doctor controls the interaction), and equal (accommodative communication where control of the interaction is shared, and the individual patient’s perspective considered). Emotional expression was measured through four items assessing preference for doctors providing reassurance and allowing patients to express their concerns (measuring the Empathy facet). Dr directs was measured through three items assessing preferences for doctor control in medical interactions. Equal was measured through six items assessing preferences for how doctors manage interactions with patients and treat them as an individual (measuring the Individualized focus facet). All items were measured on a five-point Likert scale ranging from $1=strongly \ disagree$ to $5=strongly \ agree$. Reliability of the emotional expression, equal, and Dr directs subscales were $\alpha=.82$, $\alpha=.80$, and $\alpha=.62$ respectively in the current study.

**Autonomy Preference Index**

The Autonomy Preference Index (API) was developed by Ende et al. (1989) to assess patients’ desire to be informed and make medical decisions. It consists of two scales: an 8-item information-seeking scale, and a 6-item decision-making scale. The information-seeking scale uses a five-point Likert scale, ranging from $1=strongly \ disagree$ to $5=strongly \ agree$, with higher scores reflecting increased preference for information-seeking. The decision-making scale uses a five-point Likert scale ranging from $1=strongly \ disagree$ to $5=strongly \ agree$, with higher scores reflecting a greater preference for doctors making decisions. However, scoring was reversed in the current study to aid comparison across measures. The API has good internal consistency (decision-making = .84; information-seeking = .83) and
test-retest reliability (Ende et al., 1989). Cronbach’s α in the current study was .62 and .93, for decision-making and information-seeking respectively. Dropping the item “You should decide how frequently you need a check-up” improved the reliability of the decision-making scale to .78.

**Demographics**

Demographic questions included open response questions, such as age, annual household income (specifying currency), any chronic conditions, and selected responses including the country in which they live, language spoken, gender, education, ethnicity, occupation, and religion. A copy of the demographic questions and response options are provided as supplemental materials.

*Insert table 1 about here*

**Results**

Data were analyzed using IBM SPSS 27. Fifty-four multivariate outliers were identified. Because excluding the outliers did not change the underlying pattern of results or significance of analyses, they were retained in the final analyses. As missing data was less than 5% and missing completely at random, expectation maximization was used to impute missing values (Hartley, 1967). Age was significantly correlated with most dependent variables (DV) and was included as a covariate.

We conducted a series of one-way between-subjects ANCOVAs for each of the DV’s, controlling for age. Table 2 presents the means and standard deviations for each country across DV’s. Simple effects are shown through superscripts which denote significant and non-significant comparisons. Cohen’s $d$ effect size is reported in text.

*Insert table 2 about here*

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4 Education is not reported due to issues in the way the question was interpreted across countries.
Communication

To test for differences in preferences for communication that was two-way or doctor-led, three ANCOVAs were run with CAT-Dr directs, PCC-exchange information, and Information-seeking preferences as DVs.

**CAT-DrDirects**

There was a significant main effect of country on participants’ preferences for their doctor directing communication, $F(1, 3)=63.774, p<.001, \eta_p^2=.106$. Post hoc analyses indicated participants from Hong Kong were significantly more likely to endorse a preference for doctors directing compared to those in the Philippines ($p<.001, d=.46$), USA ($p<.001, d=.58$), and Australia ($p=.000, d=.97$). Participants in the Philippines and USA did not significantly differ ($p=.548$). Participants in Australia preferred the doctor directing significantly less than those in the Philippines ($p<.001, d=.46$) and USA ($p<.001, d=.33$).

**PCC-Exchange of Information**

There was a significant main effect of country on how important participants considered an exchange of information, $F(1, 3)=76.813, p<.001, \eta_p^2=.126$. Post hoc analyses indicated participants in the Philippines felt exchanging information was significantly more important than those in Australia ($p=<.001, d=.43$), Hong Kong ($p=.000, d=.80$), and the USA ($p=.000, d=.99$). Participants in Australia were significantly different to those in Hong Kong ($p<.001, d=.36$) and the USA ($p=.000, d=.51$), and Hong Kong participants were significantly more likely than USA participants to feel an exchange of information was important ($p=0.02, d=.13$).

**Information-seeking Preferences**

There was a significant main effect of country on participants’ preferences for doctors providing information, $F(1, 3)=13.629, p<.001, \eta_p^2=.025$. Participants in the USA endorsed significantly lower preferences for information than participants in the Philippines ($p=<.001$, $d=.46$).
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$d=.29$), Australia ($p<.001$, $d=.36$), and Hong Kong, ($p<.001$, $d=.38$). Preferences in Hong Kong were not significantly different to those in the Philippines ($p=.987$) or Australia ($p=.979$), nor were those in the Philippines and Australia significantly different ($p=1.000$).

Figure 1: Mean scores on scales measuring preferences for communication.

**Decision-making**

To test for differences in preferences in decision-making, an ANCOVA was run with the decision-making sub-scale of the API. There was a significant main effect of country on participants’ preferences for participating in decision-making, $F(1, 3) = 8.947$, $p<.001$, $\eta^2_p = .016$. Post hoc analyses indicated participants in Australia wanted significantly more autonomy in decision-making compared to those in the USA ($p<.001$, $d = .17$), Hong Kong ($p<.001$, $d = .32$), and the Philippines ($p<.001$, $d = .23$). Those in the USA were not significantly different to the Philippines ($p=.99$) or Hong Kong ($p=.99$), nor were Philippines and Hong Kong significantly different from each other ($p=1.00$).

**Empathy**

To test for differences in preferences for empathy across countries, two ANCOVAs were run with CAT-emotional expression and PCC-respond to emotion as DVs.

**CAT-Emotional Expression**
There was a significant main effect of country on participants’ preferences for doctors to use communication that encouraged emotional expression, $F(1, 3)=10.069$, $p<.001$, $\eta^2_p=.018$. Post hoc analyses indicated participants in Australia were not significantly different to those in the Philippines ($p=.128$) or the USA ($p=.056$), but felt doctors should encourage emotional expression significantly more than participants in Hong Kong ($p=.043$, $d=.17$). Participants in the Philippines felt doctors should encourage emotional expression significantly more than those in the USA ($p<.001$, $d=.36$) and Hong Kong ($p<.001$, $d=.36$). Participants in the USA and Hong Kong were not significantly different ($p=1.00$).

**PCC-Respond to Emotion**

There was a significant main effect of country on how important participants felt it was that their doctor respond to their emotions, $F(1, 3)=16.426$, $p<.001$, $\eta^2_p=.30$. Post hoc analyses indicated participants in the Philippines felt responding to emotion was significantly more important than those in the USA ($p<.001$, $d=.40$), Australia ($p<.001$, $d=.38$), and Hong Kong ($p<.001$, $d=.55$). Those in the USA felt responding to emotions was significantly more important than those in Hong Kong ($p=0.44$, $d=.18$), but not those in Australia ($p=.997$). Preferences in Hong Kong were not significantly different to Australia ($p=.185$).
Figure 2: Mean scores on sub-scales measuring preferences for empathy.

**Individualized Focus**

To test for differences in preferences for being treated as an individual, two ANCOVAs were run with CAT-equal and PCC-self management as DVs.

**CAT-Equal:** There was a significant main effect of country on participants’ preferences for being treated as an equal and an individual, $F(1, 3)=26.588, p<.001, \eta_p^2=.48$. Post hoc analyses indicated participants in Australia and the Philippines were not significantly different ($p=.997$). Participants in Australia and Philippines wanted to be treated as an equal significantly more than those in Hong Kong ($p<.001, d=.58$ and .49 respectively) and the USA ($p<.001, d=.41$ and .34 respectively). Hong Kong and the USA were not significantly different ($p=.141$).

**PCC-Self-management**

There was a significant main effect of country on how important participants felt it was that doctors helped them understand how to manage their health care/take care of themselves, $F(1, 3)=76.245, p<.001, \eta_p^2=.13$. Post hoc analyses indicated participants in the Philippines felt enabling self-management was significantly more important than those in Australia ($p<.001, d=.60$), Hong Kong ($p=.000, d=.86$), and the USA ($p=.000, d=1.19$). Those in Australia were significantly different to those in Hong Kong ($p=.002, d=.23$) and the USA ($p<.001, d=.46$). Hong Kong rated enabling self-management as more important than the USA ($p<.001, d=.23$).
Relationship

To test for differences in preferences regarding the importance participants placed on the relationship with their doctor, an ANCOVA was run with PCC-healing relationship as the DV. There was a significant main effect of country on how important participants felt it was that doctors foster the relationship, $F(1, 3)=69.794$, $p<.001$, $\eta^2_p=.115$. Post hoc analyses indicated participants in the Philippines felt a relationship was significantly more important than those in Australia ($p=.000$, $d=.74$), followed by those in the USA ($p=.000$, $d=1.06$) and Hong Kong ($p=.000$, $d=1.02$). Participants in Australia felt a relationship was significantly more important than those in Hong Kong ($p<.001$, $d=.30$) and the USA ($p=.001$, $d=.23$). Participants in Hong Kong were not significantly different to those in the USA ($p=0.78$).

Discussion

This study examined how culture, defined as country, influenced patients’ preferences for different facets of PCC, including communication, decision-making, empathy, individualized focus, and relationship. Limited research has considered preferences for multiple facets of PCC in different countries, and even less has explored the views of those in developing countries such as the Philippines, where values and healthcare systems differ.
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from Western countries. Overall, we found large country effects on some facets of PCC, such as preferences for doctor-led communication, relationship, and self-management, and small, if any, country effects on preferences for empathy, information, and decision-making. Our findings suggest some facets of PCC may be universal while others are not. We cautiously discuss the implications of our findings below, while acknowledging that our findings should be replicated using a larger and more rigorous sampling strategy.

Results indicated Australia and the Philippines held similar preferences, as did Hong Kong and the USA, challenging the stereotypical East/West divide. However, each country placed more emphasis on particular PCC facets. For example, Australian participants generally preferred more autonomy in decision-making and communication that acknowledged them as an individual, though effects were small. Most participants were around the mid-point on the decision-making scale suggesting they prefer a balance between autonomy and doctor-led care. We often believe autonomy is more valued in Western countries, including the USA. Our study suggests this may not be the case with preferences in Philippines, Hong Kong, and USA very similar. Alden et al (2015) also found participants in Japan and the USA did not significantly differ in their preferences for autonomy in decision-making, though those who prized independence as a cultural value were more likely to prefer autonomy in decision-making. Yet, Strull et al (1984) found doctors often overestimate patients’ preferences for making autonomous decisions.

Participants in the Philippines placed great value on the relationship with the doctor, empathy, and being involved. Conversely, participants in Hong Kong preferred more doctor-directed care, with less importance placed on the relationship. They also wanted to be informed and to be treated as an individual. Effect sizes for the comparisons between the Philippines and Hong Kong were moderate to large, suggesting that despite being Southeast Asian countries, patient values and expectations for doctors differ significantly.
Findings from the USA were perhaps most surprising, with lowest preferences for communication needing to be a two-way exchange of information, being well-informed, and individualized care. Stereotypically, we expect people in the USA to prefer active involvement in their individualized care, yet we did not find this. One possible explanation could be within country variability. The USA had the most racial/ethnic diversity of all countries in our sample, which is consistent with the country’s demographic make-up. Fongwa, Sayre, and Anderson (2008) found differences in the type of care Black, Latinx, and White patients preferred, in their USA study investigating quality care indicators. We also used a community sample recruited through MTurk rather than a solely university sample, or sample who are mostly insured and recruited through large medical centers. Thus, our findings may represent the views of more diverse community members.

There were no other country differences on preferences for information, with ratings high and remarkably similar, adding to literature suggesting being well-informed is important across cultures (Moore, 2008). Research also suggests that doctors underestimate patients’ desire for information (Strull et al., 1984), and in some cultures it is normative to withhold information from patients even when patients want honesty and transparency (Obeidat et al., 2013). Although most people desire information, our findings suggest that there may be differences in how they expect information to be provided (i.e., whether they expect the doctor to proffer or they will elicit it directly), as well as differences in how important it is that information sharing is a two-way exchange.

Across countries, participants preferred doctors encouraging expression of emotions, showing empathy, and providing reassurance. This finding is consistent with Mazzi et al (2013), who found across four European countries (UK, Italy, Belgium, the Netherlands) that people preferred empathic responses by the doctor that provided space for the patient to talk, compared to non-empathic responses that closed opportunities to discuss emotions (Mazzi et
Empathy in medical consultations is also associated with higher patient satisfaction and some health outcomes (Mercer & Reynolds, 2002; Derksen et al, 2013), at least in Western countries. However, ratings of importance of attending to emotions was not as high overall, and there were differing patterns across measures for some countries, such as Australia and the USA. Other studies have suggested the expectation that patients talk about their emotions is not universal. For example, in a study of PCC in Nepal, researchers found patients did not expect to talk about their feelings or life more broadly in discussions about their health (Moore, 2008). Research suggests people from Asia tend to demonstrate less emotional behavior and more emotional control than those from the USA (Mesquita & Karasawa, 2002), and those from collectivistic cultures are more likely generally to contain their emotions (Liu et al., 2016). While this may explain why those in Hong Kong rated this facet of PCC as relatively less important, the findings for Filipino participants highlight that we cannot generalize across Asian countries.

**Practical and Theoretical Implications**

The PCC model positions patient values and needs as central to providing care. This should mean that if a patient wants their doctor to direct care or provide empathy, then the doctor will adapt their style to meet the patient’s needs. Preferences for care that are influenced by the patient’s cultural background should be incorporated into care and should not be viewed as obstacles to the delivery of high-quality care. However, there are concerns that PCC in practice is synonymous with increasing patient participation in decision-making and exchanging information, with most research on PCC focusing on only these two facets. The focus on improving patient participation has primarily developed from research conducted in Western countries. In this vein, Dolan et al (2019) systematically reviewed studies evaluating interventions, decision aids, etc. to explicitly improve patients' participation in the process of decision-making in non-Western countries. They concluded
patients could be trained in communication skills that improved their participation rates. However, this raises the question as to whether we should be trying to make people from non-Western countries behave more like patients in Western countries. There is a growing understanding that cultural norms and values influence both doctor and patient behavior in medical interactions (Setlhare et al., 2014). We urge caution in assuming that Western norms and ideals should be applied to other countries, especially in the absence of outcome studies demonstrating the effectiveness of PCC beyond Western countries. Instead, we contend the focus should be on how doctors adapt to the needs of each patient, rather than applying a formula.

Our findings also highlight the importance of considering how questions in research are asked. As noted above, one of our measures of empathy asked about how important it was that the doctor attended to emotions, while another asked whether a doctor should attend to emotions. Surprisingly, this significantly changed the way participants responded to the question. As ‘shoulds’ or ‘oughts’ are often indicative of injunctive norms, and importance might be more reflective of personal values (Cialdini, Kallgren, & Reno, 1991), this finding may suggest a difference between expectations and values in some countries.

Measurement of PCC generally is also an issue. As outlined throughout the paper, PCC is often confused with patient-centered communication and person-centered care. Similarly, there is no consensus about which facets constitute PCC, and considering more than one facet of PCC within a study is rare. This has resulted in a plethora of measures of different facets that are not similar, making it extremely difficult to accurately explore preferences across facets of PCC in different populations. Street (2017) has similarly raised issues of measurement and conceptualization in the PCC literature. More work is needed to develop valid measures of all facets of PCC.

Limitations and future directions
Our study had limitations. First, we conceptualized culture as country. Although this approach can provide global information about what people from different countries might prefer, and considers the healthcare systems within particular countries, it is a limited measure of culture; an extremely complex construct. Relatedly, our study did not consider within-country variables that may have impacted preferences, nor individual factors other than age. Future studies should consider a broader range of individual level factors that influence preferences (i.e., chronic health conditions). Thus, further research that takes a nuanced approach to understanding the individual within their local context is needed. Our study also used convenience sampling restricting the generalizability of findings to the broader populations in each country, and relied on platforms such as MTurk and Facebook, which have limitations in terms of representativeness and selection biases (Cunningham, Godino, & Kushnir, 2017). Further research is needed to confirm our findings using a larger sample, recruited using more rigorous processes. Lastly, we did not measure all facets of PCC and translated measures developed in English to Tagalog and Cantonese. Although our study was the first to consider five facets simultaneously, future research should consider intercultural differences on patient preferences for the other facets of PCC, including coordinated care (Ekland et al., 2021). Further work is needed to establish validity of measures across cultures.

Conclusion

Our study demonstrates that there may be similarities and differences in preferences for PCC across countries, and that facets such as empathy, information exchange and decision-making are important to most people. Conversely, there appears to be significant variability for preferences for how information is exchanged and whether this is doctor directed, the importance of the relationship, and whether the doctor should promote self-management. Doctors and other health professionals are reminded that the first step in
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providing PCC is to assess what the patient wants from their provider, with our study
demonstrating the variability there can be in patient preferences within and across countries.
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References


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Table 1
Demographic information for participants (n=1641)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of participants recruited</th>
<th>Final number of participants</th>
<th>Age (yrs) M(SD)</th>
<th>Gender % F*</th>
<th>Language of survey %</th>
<th>Ethnicity %</th>
<th>Religion %</th>
<th>Occupation %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hong Kong/Mainland China</td>
<td>571</td>
<td>(515/54) 415</td>
<td>25.80(9.0)</td>
<td>66.5</td>
<td>Cantonese 56.9</td>
<td>Asian 92.5</td>
<td>Christian 16.4</td>
<td>Not employed 53.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>English 43.1</td>
<td>Caucasian 1.2</td>
<td>Buddhist 5.1</td>
<td>Professional 29.0</td>
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<td></td>
<td></td>
<td></td>
<td>Other 6.3</td>
<td>Catholic 4.1</td>
<td>Agnostic 2.4</td>
<td>Admin/Sales 12.0</td>
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<tr>
<td>Philippines</td>
<td>402</td>
<td>294</td>
<td>28.00(9.1)</td>
<td>70.2</td>
<td>English 100</td>
<td>Asian 94.9</td>
<td>Catholic 73.8</td>
<td>Professional 49.3</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>PI 2.1</td>
<td>Catholic 3.7</td>
<td>Bapt 2.7</td>
<td>Not employed 35.2</td>
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<td></td>
<td></td>
<td>Other 3</td>
<td>Agnostic 3.7</td>
<td>None/Atheist 2.4</td>
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<td>Australia</td>
<td>496</td>
<td>426</td>
<td>24.84(9.8)</td>
<td>64.2</td>
<td>Cantonese .5</td>
<td>Caucasian 77.6</td>
<td>Christian 15.3</td>
<td>Not employed 35.9</td>
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<td></td>
<td>English 99.5</td>
<td>Asian 8.5</td>
<td>Catholic 11.3</td>
<td>Professional 21.6</td>
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<td></td>
<td></td>
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<td>PI 3.1</td>
<td>Agnostic 11.3</td>
<td>Christian 11.0</td>
<td>Support worker 9.4</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>ATSI 1.9</td>
<td>Anglican 3.5</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other 8.9</td>
<td></td>
<td></td>
<td>Trade/labourer 6.3</td>
</tr>
<tr>
<td>United States</td>
<td>622</td>
<td>506</td>
<td>29.48(11.7)</td>
<td>56</td>
<td>English 100</td>
<td>Caucasian 59.5</td>
<td>Christian 29.6</td>
<td>Professional 39.5</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
<td>Asian 15.2</td>
<td>Catholic 26.9</td>
<td>None/Atheist 16</td>
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<td></td>
<td></td>
<td>Hispanic 13</td>
<td>Agnostic 9.3</td>
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<td>Black 6.8</td>
<td>Jewish 2.8</td>
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<td>Trade/labourer 7.9</td>
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<td></td>
<td></td>
<td>Other 5.5</td>
<td></td>
<td></td>
<td>Support worker 5.5</td>
</tr>
</tbody>
</table>

Note: M=mean; SD=Standard deviation; PI=Pacific Islander, ATSI=Aboriginal and/or Torres Strait Islander. * Final sample consisted only of those who identified as male or female (F).
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### Table 2

**Means and Standard Deviations of Each Country for all dependent variables.**

<table>
<thead>
<tr>
<th>PCC facet</th>
<th>Dependent Variable</th>
<th>Hong Kong M(SD)</th>
<th>Philippines M(SD)</th>
<th>United States (US) M(SD)</th>
<th>Australia M(SD)</th>
<th>Total M(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
<td>CAT-Dr directs</td>
<td>3.99(.65)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.64(.80)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3.54(.79)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3.28(.74)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>3.60(.79)</td>
</tr>
<tr>
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<td>PCC-Exchanging information</td>
<td>4.06(.73)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.64(.44)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.95(.65)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>4.32(.77)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>4.20(.72)</td>
</tr>
<tr>
<td></td>
<td>API-Information-seeking preferences</td>
<td>4.17(.86)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.11(1.25)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.75(1.12)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>4.12(1.14)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.01(1.11)</td>
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<tr>
<td><strong>Decision-making</strong></td>
<td>API-Decision-making</td>
<td>2.76(.68)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.80(.80)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.85(.80)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3.00(.83)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.85(.81)</td>
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<tr>
<td><strong>Empathy</strong></td>
<td>CAT-Emotional expression</td>
<td>4.31(.68)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.53(.63)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.30(.65)&lt;sup&gt;bc&lt;/sup&gt;</td>
<td>4.43(.64)&lt;sup&gt;ab&lt;/sup&gt;</td>
<td>4.38(.66)</td>
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<tr>
<td></td>
<td>PCC-Respond emotions</td>
<td>3.78(.88)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.24(.78)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.93(.78)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>3.91(.92)&lt;sup&gt;bc&lt;/sup&gt;</td>
<td>3.94(.85)</td>
</tr>
<tr>
<td><strong>Individualized focus</strong></td>
<td>CAT-Equal</td>
<td>4.20(.57)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>4.49(.61)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.29(.61)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>4.51(.53)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.36(.59)</td>
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<td>PCC-Enable self-management</td>
<td>4.04(.74)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.59(.48)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.87(.69)&lt;sup&gt;d&lt;/sup&gt;</td>
<td>4.19(.77)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>4.12(.74)</td>
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<tr>
<td><strong>Relationship</strong></td>
<td>PCC-Healing relationships</td>
<td>3.86(.74)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.51(.51)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.92(.60)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.07(.67)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>4.05(.68)</td>
</tr>
</tbody>
</table>

*Note.* Countries with the same superscript are not significantly different to each other. Countries with different superscripts are significantly different at the *p*=.05 level. Scores range from 1-5 with high scores indicated greater preference/importance.