

# Providing lifestyle advice to people with type 2 diabetes from different cultures: A qualitative investigation

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**Cross-cultural communication between clinicians and local people, especially in relation to type 2 diabetes, is often under researched. The referral system in Saudi Arabia is similar to that of the NHS, and international medical graduates (IMGs) are heavily relied on in the country to provide diabetes care to local people. IMGs often do not share the same culture as the local people, yet are required to deliver culturally sensitive care. This study explores the experiences of general practitioner IMGs and people with type 2 diabetes in regards to how lifestyle advice is provided in the clinic. It is hoped that the recommendations arising from this study will improve cross-cultural interaction and raise awareness of the challenges not only in Saudi Arabia but also in the UK.**

It is crucial for physicians in cross-cultural settings to familiarise themselves with patients' culture in order to provide care that is responsive to the recipients' perspectives. The need for this familiarisation is particularly important when managing chronic health conditions, such as diabetes, where patients need to be encouraged to engage in ongoing self-management away from the consultation room.

The demand for health care in Saudi Arabia exceeds the supply of local GPs, so doctors from other countries (international medical graduates [IMGs]) form around 80% of the total physicians working in the country. The referral system in Saudi Arabia is similar to that of the NHS – patients first present their symptoms to their GPs who are assigned to community-based primary health care clinics (PHCCs) around the country. People with chronic health conditions, such as type 2 diabetes, are followed by GPs at the PHCCs, and, as such, IMGs are heavily relied on to provide diabetes care, including providing culturally sensitive lifestyle and behavioural advice. As people with type 2

diabetes have a long-term relationship with their GPs, these relationships need to be built on good communication and trust. Evidence shows that good communication and trust improve overall self-management and glycaemic control and that a lack of communication and trust may result in medication non-adherence (Piette et al, 2005; Heisler et al, 2007).

While most research has focussed on experiences of local physicians caring for people from minority ethnic populations, this investigation aims to explore the experiences of general practitioner IMGs providing lifestyle advice to local people with type 2 diabetes. It is hoped that recommendations will arise that will improve the quality of non-local physician–patient interaction in type 2 diabetes care in Saudi Arabia, which will be useful in also improving cross-cultural interactions in the UK.

## Method and outcomes

### Participants

See *Box 1* for the method. Of the 21 IMGs initially invited, 19 agreed to take part (12 male, 7

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### Article points

1. More than 30% of people, in some countries such as Saudi Arabia, have diabetes and most are cared for by international medical graduates (IMGs). Cross-cultural communication between clinicians and local people, especially in relation to type 2 diabetes, is often under researched.
2. Most of the IMGs surveyed believed they had the capacity to advise local people who have type 2 diabetes in regards to lifestyle advice. Local people in this survey appear to undervalue the IMGs' abilities because of differences in culture and a perceived lack of understanding.
3. The findings of the current study could be applied to all countries where medical cross-cultural interaction is needed.

### Key words

- Cross-cultural issues
- Minority physicians
- Patient education

### Authors

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**Box 1. Method.**

**Sampling and recruitment**

Twenty-one international medical graduates (IMGs) working within a hospital setting were invited to take part in a focus group discussion to gain an understanding of the issues relating to the provision of lifestyle advice to local people with type 2 diabetes. Fifteen GP IMGs working in eight primary health care clinics (PHCCs) from neighbourhoods of different socioeconomic levels were invited to take part in a semi-structured interview. Purposive sampling was used to maximise diversity in terms of age, gender, time since diagnosis and level of education (i.e. to ensure the inclusion of male and female IMGs with a range of age and years of experience). In order to achieve a deeper understanding of the issues raised, follow-up semi-structured interviews were conducted. Eleven IMGs were approached to take part in the follow-up interviews. A purposive sample of local people with type 2 diabetes, over 20 years of age was recruited from the PHCCs and the hospital.

**Data collection**

The focus group discussion was conducted in English, while interviews were conducted in English or Arabic, based on IMGs' preferences. Data were collected in 2011 and 2012 from IMGs working at a hospital-based primary care clinic using open-ended questions to stimulate discussion. The interview guides were adopted from findings of similar previous studies (Fiscella et al, 1997; Dorgan et al, 2009) and modified according to the Saudi culture. The semi-structured interviews with IMGs were conducted at PHCCs or the hospital, apart from two telephone interviews with two of the male IMGs. The interviews covered the issues raised in the focus group in more detail, such as how IMGs provide advice to people with type 2 diabetes, and their views on providing care to the local population.

**Data analysis**

All interviews were conducted, audio-recorded, transcribed verbatim and translated where necessary by NAA. A coding frame was agreed between the research team, and all were involved in coding and analysing data to identify common descriptive themes, which were grouped into clusters. The emerging themes were investigated until saturation was achieved. During the study, the emerging themes were regularly reviewed and discussed by the research team to inform subsequent interviews. NVivo 10 software was used to store and retrieve sections of the data.

female). The mean age was 47 years (range 32–59 years) and the mean length of time working as an IMG in Saudi was 13 years (range 2.5–29 years). Eight IMGs agreed to take part in the focus group; comprising three South Asian physicians of Pakistani and Kashmiri origin, and five Arab physicians of Sudani, Egyptian and Syrian origin. Of the 11 IMGs approached for follow-up interviews, five agreed to participate.

Sixteen local people with type 2 diabetes agreed to take part in an interview (eight male, eight female; mean age 56 years [range 42–67 years]

and 53 years [range 35–70 years] respectively).

**Themes**

Three themes emerged from the qualitative analysis: physical activity and the local lifestyle and culture; diet, the food environment and social etiquette; and patients' understanding and acceptance of lifestyle advice.

**Physical activity and Saudi lifestyle and culture**

The majority of the IMG physicians acknowledged that the traditional, conservative nature of Saudi society made it difficult for patients to exercise, particularly for women. They were aware that they needed to adapt to provide culturally appropriate lifestyle advice in order to provide achievable management plans:

“If the doctor thinks with her mentality, culture and habits, she will never understand that it is socially unacceptable in Saudi Arabia for a woman over 40 years of age to visit the gymnasium.”  
(IMG, female, Syrian)

One strategy put forward by a male IMG was to ask male patients to walk to a mosque that was further away than the mosque they usually attended, which indicates the IMGs awareness of local peoples' religious needs. Another strategy was advising women to exercise at home, which showed IMGs' awareness of how the local culture influences patients' lives, as well as avoiding exposing patients to societal taboos such as females exercising in public spaces. It also showed that IMGs are familiar with the most common housing structure (a large house surrounded by an enclosed, private yard). However, some patients contradicted the IMGs' awareness of the cultural environment and did not feel their physician was providing appropriate exercise advice:

“She [her IMG] told me to walk every other day and go to the gym but you know...!”  
(Patient, female)

**Diet, the food environment and social etiquette**

The IMGs showed an awareness of places where

healthy food was available in the area. A female patient talked about her experience with her IMG, who had not only advised her about what type of rice to cook, but also was able to tell her where to purchase the rice. However, not all patients were satisfied that the advice provided on food and diet was culturally sensitive. For example, one female patient explained that a physician had once suggested that her aunt eat broccoli, a vegetable not produced in the region and unknown to most older people. Familiarity with the traditional food customs and social etiquette is vital for IMGs to provide patients with the appropriate guidance.

Patients reported that their IMGs were not aware of traditional social etiquette, believing that this was because they do not integrate with the local people to an extent that would make them aware of these details, for example:

“Unless they [IMGs] live here for a long period of time and integrate with Saudi people to understand [the unacceptability of rejecting food at social gatherings], they won’t be able to help properly.” (Patient, male)

When probed in the follow-up interviews, most of the IMGs expressed some familiarity with local customs and habits with regards to diet, social etiquette and/or physical exercise and felt able to provide their patients with practical advice, for example:

“Don’t reject [food] totally; you can make healthy choices. [...] take a piece of meat with bread, and a piece of fruit, and instead of tea or green tea with sugar you can take coffee [...]. You can make healthy choices.” (IMG, male, Pakistani)

### Patients’ understanding and acceptance of lifestyle advice

Some patients did not have confidence in their physicians’ ability to provide culturally appropriate lifestyle advice. In the follow-up interviews, the IMGs discuss why patients may not feel confident or did not acknowledge their efforts in supporting them to manage their condition.

“As the patient enters the room, it’s at the back of her mind that, ‘The person I am visiting is not Saudi. She doesn’t belong to my culture; she doesn’t belong to the environment where I’m living.’ ... They may think that she [the IMG] doesn’t know what their actual culture is, so the education she is giving is not applicable.” (IMG, female, Bangladeshi)

Dialect or language discordance was also believed by IMGs to influence patients’ attitudes toward the lifestyle advice given. IMGs explained that it could be difficult for patients to remember information provided by their physicians if it was not in an understandable dialect, Arabic being the preferred language among local people.

IMGs’ limited skills and experiences in providing culturally sensitive lifestyle advice were one of the explanations for patients’ attitudes. According to a small number of IMGs interviewed, they felt that they themselves sometimes lacked the skills to enable them to use their knowledge about culture to agree on lifestyle plans for their patients and provide practical alternatives. One IMG, with 4 years’ experience working in the country, noted the following:

“Maybe the expatriate doctor is familiar with the customs and habits but cannot link her information with providing advice to patients, it is just not in her mind because she does not live that culture, she just knows it.” (IMG, female, Egyptian)

Another IMG, who has worked in Saudi for 3 years, was still not sure about the right way to change culturally-related behaviours of her patients:

“If you straightaway say, ‘this thing is wrong’, then you are saying your father was wrong. Your mother was wrong.” (IMG, female, Bengali)

A combination of patients’ preconceived ideas about IMGs; their own attitude to accepting the advice; and IMGs’ inability to sometimes communicate information effectively, all provide

### Page points

1. The majority of international medical graduates were aware of dietary and social etiquette of the local population.
2. Some patients did not have sufficient confidence in their physicians’ ability to provide culturally appropriate lifestyle advice.
3. A combination of patients’ preconceived ideas about international medical graduates (IMGs); their own attitude to accepting the advice; and IMGs’ inability to sometimes communicate information effectively, all provide an explanation for poor cross-culture physician–patient relationships.

### Page points

1. Physicians hold an important role in helping educate people, especially those with chronic health conditions such as type 2 diabetes, but delivering culturally appropriate care has proved to be a challenging task in cross-cultural contexts.
2. The findings of the current study are relevant to, and could be applied to, all countries where medical cross-cultural interaction is present, such as in the UK.

an explanation for poor cross-culture physician–patient relationships.

### Discussion

Physicians hold an important role in helping educate people, especially those with chronic health conditions such as type 2 diabetes. Delivering culturally appropriate care has proved to be a challenging task in cross-cultural contexts (Fernandez et al, 2004; Mehler et al, 2004; Stone et al, 2005; Ryan et al, 2008). However, the experiences and challenges faced by immigrant physicians from different cultures delivering care to local patients are under explored. This study exploring the experiences of IMGs in Saudi Arabia with local people with type 2 diabetes has found that cross-culture interactions can be improved. IMGs reported they were familiar with the local culture and most felt able to provide culturally appropriate advice to their patients. However, patients underestimated the IMGs' knowledge and did not always trust their ability to provide culturally appropriate advice. The IMGs were aware of peoples' negative attitude regarding the advice they provided. This awareness could unfavourably affect the IMGs approach by, subconsciously, encouraging them to adopt a less flexible approach and thus reinforce the latter's attitude.

Some IMGs suggested that the perceived poor ability to provide cross-cultural care could be due to the fact that their knowledge about local culture is theoretical and they lack direct experience of the local culture. While IMGs are expected to develop the necessary skills to be culturally competent, there are some barriers that may hinder this progress, such as patients' stereotypical views of IMGs lacking the necessary skills to approach local patients. Previous research supports this argument, suggesting that patients prefer local physicians to IMGs (Zeighami et al, 1978; Louis et al, 2010). The current study showed that being cared for by an IMG can act as a barrier to patient trust and positive outcomes. This was also supported by Fiscella et al (1997) who concluded that language and cultural differences between IMGs and patients might be reflected in the care that is delivered or be perceived by their patients as

the physicians not appropriately participating in their care.

Patients' attitudes toward IMGs, along with the lack of IMGs' cultural competency education and training, could contribute to the suboptimal care and poor access to programmes targeting chronic health conditions (Al-Ahmadi and Martin, 2005). IMGs are required to pass a licensing exam that tests their biomedical knowledge before they are able to work in Saudi Arabia and all IMGs have worked as qualified physicians in their countries of origin previously. Their clinical knowledge is evident. Nevertheless, IMGs must also master complex cultural notions and combine them to successfully improve the quality of care for local people with type 2 diabetes.

### Broader context

This paper adds to the existing literature by focusing both on the experiences of one group of non-local physicians (IMGs) providing care to local people in Saudi Arabia, as well as considering the patients' voice. While IMGs' cultural competence training may contribute to their ability to deliver culturally sensitive, high-quality care, it needs to be coupled with culturally appropriate patient information in order to influence current attitudes and beliefs, which may reduce the effectiveness of care delivered by IMGs.

The findings of the current study are relevant to, and could be applied to, all countries where medical cross-cultural interaction is present, such as in the UK. Both local doctors delivering lifestyle education to minority ethnic groups and IMGs delivering lifestyle advice to local people could benefit from reflecting on whether the lifestyle guidance they provide is as appropriate as possible.

### Implications for practice

#### Shared language

As with other developed countries, non-Arabic-speaking IMGs could be given an Arabic language assessment before they are allowed to work in another country. Alternatively, they could be empowered by language support when performing their role.

### Cross-cultural training

Potentially, cross-cultural care and trust issues could be tackled by providing IMGs with cultural competence training programmes. These programmes have been demonstrated to increase physicians' skills and patients' satisfaction (Beach et al, 2005; Horvat et al, 2014). However, findings from this study indicate that this should be coupled with emphasising to patients the role IMGs play in delivering accessible high-quality health care to patients to enhance a trusting relationship between physicians and the local population. This kind of initiative may reduce negative, preconceived ideas about IMGs' knowledge and capability in terms of providing culturally appropriate care.

### Study limitations

Being a female researcher interviewing male participants in a conservative culture may have affected the depth of the interviews, as the male patients may have been discouraged from speaking freely and comfortably. For example, in accordance with cultural norms, Saudi male patients avoided eye contact with the researcher and sometimes preferred to provide concise, short responses than share their experiences in greater depth. As a result, more in-depth interviews were held with female interviewees and a male interviewee who chose to be interviewed by telephone.

### Conclusion

The study found that IMGs were culturally aware and most had the ability to provide culturally sensitive lifestyle advice. Nevertheless, patients felt that IMGs were not always able to provide culturally appropriate lifestyle advice. While improving IMGs' cultural competence may contribute to delivering high-quality diabetes care, attention must be given to improving patients' understanding and to developing the physician–patient interaction. ■

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### Declaration

This study was funded by King Saud University, Riyadh, Saudi Arabia. Ethical approval was obtained from the Saudi Ministry of Health International Review Board, to collect data; and by the ethics committee at the School of Health and Related Research at the University of Sheffield, UK, to conduct the study, analyse data and discuss findings. The authors declare no conflicts of interest.

Al-Ahmadi H, Martin R (2005) Quality of primary health care in Saudi Arabia: a comprehensive review. *Int J Qual Health Care* **17**: 331–46

Beach M, Price E, Gary T et al (2005) Cultural competency: a systematic review of health care provider educational interventions. *Medical Care* **43**: 356–73

Dorgan K, Lang F, Floyd M, Kemp E (2009) International medical graduate–patient communication: A qualitative analysis of perceived barriers. *Academic Med* **84**: 1567–75

Fernandez A, Schillinger D, Grumbach K et al (2004) Physician language ability and cultural competence. *J Gen Intern Med* **19**: 167–74

Fiscella K, Roman-Diaz M, Lue BH et al (1997) 'Being a foreigner, I may be punished if I make a small mistake': assessing transcultural experiences in caring for patients. *Family Practice* **14**: 112–6

Heisler M, Cole I, Weir D et al (2007) Does physician communication influence older patients' diabetes self-management and glycemic control? Results from the Health and Retirement Study (HRS). *J Gerontol A Biol Sci Med Sci* **12**: 1435–42

Horvat L, Horey D, Romios P, Kis-Rigo J (2014) Cultural competence education for health professionals. *Cochrane Database of Systematic Reviews*: CD009405

Louis W, Lalonde R, Esses V (2010) Bias against foreign-born or foreign-trained doctors: experimental evidence. *Med Educ* **44**: 1241–7

Mehler P, Lundgren R, Pines I, Doll K (2004) A community study of language concordance on Russian patients with diabetes. *Ethn Dis* **14**: 584–8

Piette JD, Heisler M, Krein S, Kerr EA (2005) The role of patient–physician trust in moderating medication nonadherence due to cost pressures. *Arch Intern Med* **15**: 1749–55

Ryan AM, Gee GC, Griffith D (2008) The effects of perceived discrimination on diabetes management. *J Health Care Poor Underserved* **19**: 149–63

Stone M, Pound E, Pancholi A et al (2005) Empowering patients with diabetes: a qualitative primary care study focusing on South Asians in Leicester, UK. *Fam Pract* **22**: 647–52

Zeighami B, Zeighami E, Mehrabanpour J et al (1978) Physician importation--a solution to developing countries' rural health care problems? *Amer J Pub Health* **68**: 739–42

**“While improving international medical graduates' cultural competence may contribute to delivering high-quality diabetes care, attention must also be given to improving patients' understanding and to developing the physician–patient interaction.”**

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