Sub-Saharan African Students' Experiences, Perceptions, and Expectations with American Health Services: An Intercultural Challenge

Claudia L. McCalman & Carol M. Madere[1]
Southeastern Louisiana University

Abstract

Understanding patients' cultural expectations could contribute to better health outcomes and decrease cultural health disparities. This qualitative pilot study objective was to explore experiences, perceptions, and expectations of males and females Angolan students as patients in America. Eighteen face-to-face interviews were conducted at a Midwestern university. Burgoon's expectancy violation theory (1991) was the theoretical background. Results revealed as positive expectation violations an advanced technology, quality of services, medicine availability, and emphasis on preventive care. Negative expectation violations included high service costs, complicated insurance system, short medical encounters, and difficulty in building relational history with providers. The study also revealed that culturally related communication barriers as well as negative violations of expectations hinder the quality of intercultural clinical encounters and can affect health outcomes. Participants emphasized the importance of these interpersonal relations and their connection with perceptions of caregivers' professional competence. International patients/students revealed that they believe friendliness on the part of the caregiver is a signal that they are dealing with a "good" doctor or nurse. Intercultural competence is an important asset of caregivers who work in multicultural clinics and in college health. Practical implications emerged in international advising and clinician's education.

Keywords: Sub-Saharan Africa, Angola, International Students, Expectancy Violation Theory, Provider-International Patient, College Health.

The recent change in the United States demographics (U.S. Census Bureau, 2005) reflects increased diversity of the population and represents challenges in disease management, provider-patient relationships, and quality of health care delivery. Understanding a patient's culture and worldview helps in the delivery of culturally competent care and can contribute to positive health outcomes. Traditionally, most patients in the U.S. healthcare system have been European Americans and have been

[1] Claudia L. McCalman (Ph.D., Pennsylvania State University) is an associate professor in the Communication Department at Southeastern Louisiana University, Hammond, LA. Carol M. Madere (Ph.D., University of Southern Mississippi) is an assistant professor in the Communication Department at Southeastern Louisiana University, Hammond, LA, cmadere@selu.edu. Correspondence to: Claudia L. McCalman, Southeastern Louisiana University, Department of Communication, SLU 10451, Hammond, LA 70448, cmcccalman@selu.edu. Phone: (985) 549-2105, Fax #: 985- 549-5407.
Acknowledgement: The authors thank the Angolan students who participated and dedicated their time and attention to this project. Without their help this study would not be possible.

treated mostly by European American caregivers. This congruence of culture and values has been the assumed norm in patient-provider interactions. However, in the last 20 years and in the next decades the population of several minority groups in the U.S. is expected to increase while the population of European Americans is expected to shrink (U.S. Census Bureau, 2005). Recent immigration has also contributed to greater diversity. Previous research found that the greater the class, ethnic, and cultural disparities between caregivers and patients, the more challenging it becomes to communicate (Cole, 2002; Heuer, Bengiamim & Downey, 2001; Ulrey & Amason, 2001). Recently, scholars in several disciplines have been stressing the role of culture in health care delivery and the importance of effective intercultural communication for positive health outcomes (duPre, 2004; Gao, Burke, Somkin, & Pasick, 2009; Wright, Sparks & O'Hair, 2008).

A specific group of patients that has been increasingly contributing to diversity in health care is the population of international students at U.S. campuses. Many of them eventually became patients at university health centers or local communities. Depending on the condition of their illness they may even seek specialty medical services in communities outside the campus, and consequently become patients in the U.S. health care system. In order to estimate the magnitude of this population, it is convenient to take a look at the Open Doors 2008 (IIE/U.S. Department of State's Bureau of Educational/Cultural Affairs), the annual report on international academic enrollment from the Institute of International Education. This report mentioned 623,805 international students attending American universities in the 2007-2008 academic year.

Although some international groups of patients such as Mexicans (Barron, Hunter, Mayo, & Willowghby, 2004; Unger & Molina, 2000) and Asians (Sun, Zhang, Tsoh, Wong-Kim, & Chow, 2007; Juon, Kim, Shankar & Han, 2004; Yu, Hong & Seeto, 2003) have been receiving scholarly attention, other groups such as the sub-Saharan African population in the U.S., have been understudied. This lack of information poses serious challenges to American university health centers, college health caregivers, and community health providers. A better understanding of this African population would contribute to decreasing uncertainty, facilitating better health outcomes, and decreasing cultural health disparities. Although data on enrollment of students from every African nation at U.S. universities were not easily available, Open Doors 2008 (IIE/U.S. Department of State's Bureau of Educational/Cultural Affairs) reported that countries in Sub-Saharan Africa are continually sending students to

America. A better understanding of cultural clinical expectations would help to inform and educate providers on how to deliver culturally competent care and perhaps decrease health disparities by fostering better understanding and facilitating positive health outcomes. It could also help university staff, especially international students' advisors to reconsider, update, and redesign material and approaches to better equip newly arrived students.

The purpose of this study is to investigate experiences, perceptions, and expectations about health care delivery from a volunteer group of international students originally from Angola, who was also patients in the U.S. health care system. Specifically, the study focuses on behaviors of health providers that may contribute to negative or positive expectations and the outcome of such behaviors on patients' satisfaction, trust, and adherence to prescribed recommendations. Ultimately, we expect to gain new insights on how to effectively communicate with Sub-Saharan patients by examining their clinical encounters. We also expect that these new insights will contribute to the content and design of effective training sections and counseling of newly arrived internationals students at their campuses.

Cultural Sensitivity, Competence, and Intercultural Communication

How caregivers can become culturally competent? First, they need to have cultural sensitivity, and "willingness to use cultural knowledge while interacting with patients and considering culture during discussions and recommendations for treatment" (Ulrey & Amason, 2001, p. 450.) This encompasses effective 'clinical' intercultural communication between the parties. Second, in clinical encounters communication competence (see Spitzberg & Cupah, 1989; Wiseman, Hammer, & Nishida, 1989) is much needed. These scholars explain that competence encompasses an impression or judgment that one individual makes about another. People may perceive others as competent or incompetent by considering the verbal and nonverbal behaviors that are expressed during interaction. Spitzberg (2000) adds that as communicator motivation, knowledge, and skills increase, communicator competence also increases. The combination of these elements leads individuals to perform confidently in their encounters. It may be that perceptions of intercultural communication competence or incompetence from Angolans about caregivers may affect health outcomes. It is possible to be proactive about our communication competence skills. It is also possible

to communicate effectively in medical contexts if parties are willing to do so, and learn when and how to be effective communicators (Ulrey & Amason, 2001).

Several models of cultural competence are available in the medical care and human communication literature, including Campinha-Bacote, (2002); Cole, (2002); Dennis and Giangreco, (1996); Spitzberg (1997, 2000). As Campinha-Bacote explains, becoming competent in intercultural encounters is an ongoing process. Thus, to provide culturally sensitive services caregivers need to continuously improve their ability to work within the cultural context of the patient (see Campinha-Bacote's model, 2002).

Cultural practices and other relational themes can affect patients' perception of provider-patient effective communication (Gao, Burke, Somkin, & Pasick, 2009). They found that when doctors and patients come from different cultural and ethnic backgrounds physicians may not address cultural barriers related to certain procedures. By the same token, the patients may not volunteer culture-related concerns related to medical screenings. Such barriers and expectations can hinder the quality of the clinical encounter. However, by lessening these barriers providers can make significant impact on existing health disparities among ethnic, racial, and international groups (Seid, 2008.)

But what are some specific consequences of caregivers' lack of ability and competence in intercultural communication? The most common consequences are patients' lack of trust and satisfaction (Balkrishnan, Dugan, & Camacho, 2003) miscommunication, refusal of tests and treatments, lack of adherence to medical orders, and stress (Doescher, Saver, Franks & Fiscella, 2000; Kreps & Thornton, 1992; Van Servellen, 2009.) In the specific case of trust, Dibben and Lean (2003) found that interpersonal trust between parties was related to adherence to prescribed regimens. It appears that for patients the elements of satisfaction, trust, and compliance are contributors to better health outcomes.

Specific cultural barriers emerge in college health and need to be overcome to ensure optimal care delivery. The first is the unfamiliarity of U.S. clinicians with tropical diseases such as malaria, dengue fever, and tuberculosis. For example, Norton (2000) discussed the importance of health care personnel understanding tuberculosis and the cultural aspects of the international student clientele. The second cultural barrier is that of the Western cultural values on which much of American medicine is based, especially in the field of mental health counseling. For instance, Moore and Constantine (2005) found that students from collectivistic cultures, particularly those

from Africa, Asia and Latin America, utilized social support seeking and forbearance to cope with their problems and concerns. Carr, Koyama and Thiagarajan (2003) investigated the women's support group for Asian students. They found that social support can be a powerful coping resource for international students because it validates the students' experiences, relieves them of the difficulty of explaining their problems in English, and releases them from the cultural stigma related to emotional problems. Certain cultures stress privacy, which prevents patients from seeking help from outsiders.

The demands for cultural adjustments frequently place international students at greater risk for psychological problems than students in general (Mori, 2000). Psychological problems may prompt physical symptoms. Internationals have linguistic, academic, interpersonal, health insurance, lack of social support and financial problems that constitute unique sources of stress and frustration. These stressors, coupled with underutilization of counseling services and problems with nutrition produce loss of sleep and appetite, low stamina and energy levels, and other symptoms that prompt frequent visits to health care services. Therefore, clinician education on cultural self-awareness and on acquiring culturally relevant therapeutic skills is much needed (Mori, 2000).

Caregivers' understanding of patient expectations is crucial to patients' satisfaction (Kravitz, 2001; Zemencuk, Hayward, Skarupski, & Katz, 1999) and to patients' perceptions of a high quality care delivery. However, Halley and Pargeon (2000) revealed that providers were unable to judge patients' satisfaction accurately. Another study (Perron, Secretan, Vannotti, Pecoud & Favrat, 2003) about immigrant patients' expectations at a multicultural clinic reported that physicians had inaccurate perceptions of their patients' expectations. These scholars concluded that by understanding patients' expectations we can improve health care use and delivery in multicultural clinics. Failure to identify patients' expectations can lead to patient dissatisfaction with care, lack of compliance, trust, and also inappropriate use of medical resources. Then, there is a need to improve clinicians' communication skills that should be the basis for specific intercultural communication training (Perron, et al., 2003). To better understand the international patients' expectations in their clinical encounters, we take a closer look at one of the main theories of message reception and processing, the Expectancy Violation Theory.

Expectancy Violation Theory in Health Care

Using Expectancy Violation Theory (Burgoon, 1991; Burgoon, Newton, & Walther, 1989) this study focused on the expectation violation experiences and perceptions of Angolan students at an American university. This theory describes an individual's action, verbal or nonverbal, expected or unexpected, followed by an interpretation of the action to which a "positive or negative valence" is applied based on potential rewards (Burgoon, 1991; Burgoon, Newton & Walther, 1989; Griffin, 2000; Manusov & Hedge, 1993.) How do patients respond when clinicians violate their expectations? People have expectations about the behavior of another person based on social norms, previous experience with the other person, and the context in which the behavior appeared. Positively valenced violations produce better relational outcomes than do negatively valenced ones, and uncertainty-decreasing violations produce more positive outcomes than uncertainty-increasing situations (Afifi & Burgoon, 2000.)

Different perceptions and expectations between patients and providers may hinder the relationship and affect the perceptions of the international patients. Negative violations can result in delay in seeking medical attention, dissatisfaction, lack of trust, and non-compliance with physician orders, all of which produce negative health outcomes. But what is the health care contextual background of our Angolan patients?

Participants' Country of Origin

Angola's health indicators are some of the worst in sub-Saharan Africa (Connor, Rajkotia, Lin, & Figueiredo, 2005). The country supports three subsystems of health care. The first is the public health care system, corresponding to three levels of government (national, provincial, and municipal). It lacks human and institutional capacity, with supervision and insufficient public health financing as a constant factor. The second subsystem is the private health care sector. It is comprised of for profit and not for profit institutions (e.g., NGOs and local churches). Petroleum and other foreign or multinational corporations operating in Angola provide the third health subsystem. Care is offered at the companies' facilities to employees, their nuclear families and sometimes to their extended families.

Based on the preceding research, the following research questions were advanced:

RQ1: What are the perceptions and experiences of these international students as patients, when interacting with American health care providers?

RQ2: What are these international students' positive and negative expectations as patients, regarding the clinical encounter with American health care providers?

Method

Study Design and Sample. Author's preliminary informal conversations within Portuguese native speakers on campus revealed that the Angolan government, petroleum companies, and international companies operating in Angola send expatriates and/or their children to a few chosen universities in America. Their objectives are to acquire technical knowledge and further their education. Being part of that Portuguese campus community, one of the authors had the opportunity to closely study this population of sub-Saharan individuals that is rarely available. Although we cannot generalize that Angolans represent all other sub-Saharan African students, by further understanding this group we provide information on one of the most understudied segment of international students in America (Open Doors Report, 2008).

This was a pilot interview study in which data were collected from a convenience sample of 18 Angolan college students who were attending a Midwestern university. Glazer and Strauss (1967) indicate that data collection should continue until theory saturation is reached, that is, until data collection appears to no longer be revealing new concepts or insights into the phenomenon being studied. In light of this, interviewing of respondents continued until responses seemed repetitious of previous interviews, and this resulted in a sample of 18 students. All participants had health problems in the preceding months. In fact, participation pre-requisite was that all participants had to have had at least one clinical visit in the U.S. in the preceding 12 months. All individuals also had experiences with both the public and private health care systems in Angola. Participants were identified via either word-of-mouth or recruiting flyers both in English and Portuguese that were displayed on strategic sites around campus, including the Office of International Students, library, health clinic, and gym. Institutional Review Board approval was obtained at the university where participants were recruited.

Among the 18 participants (N=18), 12 were females (67%) and 6 were males (33%). Their length of stay in the U.S. ranged from 1 to 9 years, with a mean of 4.1

years. Their age ranged from 24 to 34 with a mean of 27.5. Participants had a high socioeconomic status in their country of origin, had received fellowships to study in America either from their country or from international organizations, and were pursuing various academic majors (see Table 1 and 2 below). All participants had an international student visa, with the exception of a male who was married to an American citizen and had became a U.S. permanent resident.

Table 1. Demographic Profile Participants: Ages, Time, Caregiver Visits, Majors

Ages	No. of Students	Time in U.S.	No. of Students	Care-giver Visits	No. of Students	Majors*	No. of Students
23	1	1	1	2	2	Account	1
26	2	2	1	3	2	Business	4
27	2	3	4	4	6	Chemistry	1
28	2	4	5	5	1	ComputSc	1
29	1	5	2	6	3	Economics	2
30	2	8	1	7	1	Finance	3
32	1	9	1	10	1	Med Tech	1
34	1						
Mean = 27.5		Mean = 4.1		Mean = 4.7		Total = 13	

Notes: Immigration Status: All but one student had an International Student Visa. The exception was a permanent U.S. resident.
* Some students refused to answer this question.

Table 2. Demographic Profile Participants: Gender and Language

Gender Group [a]		Language of Interview [b]	
Males	6	Portuguese	14
Females	12	English	4
[a]n=18 interviewees		[b]n = 18 interviewees	

Data Collection and Procedures. Data were collected on campus via face-to-face, in-depth semi-structured interviews, with open-ended questions by a bilingual (Portuguese and English) researcher and graduate research assistant. Informed consent was obtained from each participant before the interviews began. The process of data collection lasted 6 months. Respondents were asked to answer 12 questions (see Appendix) and each interview ranged from 60 to 75 minutes. Most respondents chose to be interviewed in Portuguese because they felt more comfortable speaking in their native tongue. General instructions about the study were given at the beginning of the interview. Participants were informed that their identity would not be revealed and that their responses would be aggregated to the pool of responses from all participants.

Analysis. Participants' responses were audio taped, transcribed verbatim, and translated. The method of back-translation was used in order to establish translation

accuracy. Back-translation refers to a translation of a text back into the language of the original text. Researchers independently examined the transcripts and identified broad themes and insights offered by participants that did not fit the main themes. After independently analyzing the data, researchers discussed emerging themes, returned to individual analysis, and collaboratively decided on the final code and themes that would compose the data reporting and would address each research question. Researchers also considered connections among themes (Seidman, 2005). Codes also reflected authors' analysis of what was likely to be of theoretical importance in understanding this population's experiences, perceptions and expectations about their clinical encounters.

Results

Results are organized by research questions. Research Question #2, which investigates positive and negative expectations related to the clinical encounter with American caregivers, prompted the most extensive responses from participants. When responses to items in the questionnaire were overlapping between RQ1 and RQ 2 the authors agreed on the classification of these responses into one or other Research Question with the goal of giving structure and organization in reporting the results. Following are the Angolans' responses about their healthcare expectations, perceived characteristics of communication competence in a caregiver, health practices in Angola, issues of adherence, trust, satisfaction. Another theme, not directly related to research questions emerged from the data, the African ways of receiving and gaining social support. It is important to note that this specific sample was composed of people from moderate to high socio-economic levels who came to America to further their education. During their stay all of them had health problems and consequently had experiences with the U.S. health care system.

Research Question 1: What are the perceptions and experiences of these international students as patients, when interacting with American health care providers?

We sought the perceptions of students regarding variables that may trigger or hinder their satisfaction, trust, and adherence to medical recommendations. Students reported here their experiences in medical encounters in the U.S. and sometimes also in Angola. In this section, participants revealed caregivers' traits that prompted adherence to medical recommendations or prescriptions.

What inspires trust and satisfaction in a physician? Listening, thorough examinations, and, of course, treatment success were the main factors in building trust in the physician and satisfaction with the clinical encounter. Thus, participants considered both clinical experience and social skills in their evaluations of provider competence. Specifically, they stressed the need of four crucial elements: extension of a caregiver clinical experience, interpersonal skills, listening, successful experiences (cure) in being treated by the same physician, and time spent during medical interview as some of the pre-requisites. Referrals from family members and friends also boosted the trust level of respondents as well as respect for the physician's advanced medical training. A 27-year-old female illustrated this in her response:

"If I know that he has treated [successfully] so many people that have the same problem that I have, I may trust him better."

Respondents had little to say about trust and satisfaction with nurses, because they did not seem to consider the nurse's role in healthcare very important, due to the lack of specialization and lack of differentiated levels of the nursing profession in Angola.

What inspires adherence to prescribed regimens and medications.

Different aspects of adherence were addressed both in Research Questions #1 and #2. Adherence is necessary for clients to experience improved health outcomes. Therefore, researchers sought to understand what elements would trigger adherence to medical recommendations in these patients. People have several reasons for choosing to follow or not to follow professional prescriptions and recommendations. Once again, international students do not differ much from their American counterparts. They indicated that they follow medical orders when they are fearful of the disease they have, but grow lax about taking the prescribed medicine when they begin to feel better or when they do not like the side effects of medications.

Other international students failed to follow physicians' orders when they were prescribed antidepressants. As one student described it, "I've been depressed many times here because of the weather [long winters with snow] and because I am away from my country. You go to the doctor and they immediately prescribe antidepressants and I just don't believe in antidepressants and don't take them."

Adherence to caregiver instructions also failed when they felt their treatment was not working fast enough. As one student described it, "I know it takes time to heal the problem and everything, but sometimes, it's just too long. I'm like, okay, I'm not

taking this anymore. You've been spending money to see results and you don't see it." (24-year-old male respondent).

Others complied out of respect for the physician's knowledge, education, and professional training: "Yes, because I know that he is the doctor and I went to him because I want to feel better and know what's going on with me. And if he's a doctor, he's a professional in this career and I have to trust in him." (26-year-old female respondent).

What caregiver characteristics influence adherence to medical recommendations? Interpersonal competence emerged as a necessary pre-requisite for trust and adherence to occur. Caregivers who gave explanations about reasons for a chosen prescribed regimen also triggered trust and adherence. When a caregiver was rude or hurried, their trust in him/her and adherence to his/her recommendations suffered. In addition, participants felt it important that the physician explain the reason why the patient should follow a particular treatment plan. A participant illustrated this:

"If I feel he is caring and not trying to rush me out of the office and he takes time to explain my condition and why I have to take the medicine, probably I will take that into consideration" (27-year-old female respondent).

Research Question 2: What are international students' positive and negative expectations, as patients, regarding the clinical encounter with American health care providers?

Expectations about the other communicator can be verbal and/or nonverbal, positive or negative. Following are participant's responses about expectations in the areas of provider-patient encounter, traits of a good doctor or nurse, differences in the medical encounter in the U.S. versus Angola and how it consequently affected their expectations. Finally we investigated how these participants would help in preparing future students or relatives coming to the U.S. to avoid negative expectations related to health care.

The provider-patient encounters. Respondents noted that in Angola, there is less interaction between patients and nurses than in the U.S. and that they saw doctors in hospitals or clinics, not in doctors' offices. They noted that patients get more attention in the U.S. than they do in Angola, where there is a shortage of physicians, nurses, and supplies, especially some types of prescription drugs that many times need to be purchased in the "black market."

Respondents were also surprised (and sometimes frustrated) by the greater role that nurses play in the clinical encounter in the U.S. Some felt annoyed when, at the university health center, they asked for a doctor but a nurse conducted the clinical encounter. As one respondent put it, "In Angola, we don't talk to the nurse first. Doctors take your temperature and blood pressure."

What makes a good doctor and nurse? The responses given to this question are not unlike what Americans expect of healthcare providers. Respondents always referred to doctors as "he," as they have little to no experience with female physicians. They expected and preferred physicians who were patient with them, who took time to listen throughout the examination and who did not appear to rush the encounter. They valued good listening skills especially, because as one respondent put it, "Sometimes there are some diseases that maybe they don't have in the U.S. but exist in other countries such as malaria. If they [physicians] don't listen and get what's wrong with you, they can give you the wrong medicine" (24-year-old male respondent).

Respondents also expressed a need for physicians and nurses to communicate in laymen's terms: "Nurses should tell you in normal words or language what the doctor said and what you need to do and how to take the medicine," said a 24-year-old male respondent.

What surprised Angolans in their first U.S. medical encounter? Angolan students experienced both positive and negative expectation violation regarding their experiences with U.S. healthcare. Their surprises provide an interesting perspective on certain indigenous practices of U.S. healthcare that many Americans probably take for granted. For example, a female respondent was surprised and pleased that American gynecologists regularly check for cancer. "You're more likely to be treated in time, so that's a good thing to me," she said.

They also expressed pleasant surprise upon receiving free samples of medicine at the conclusion of their doctor's visits, but unpleasant surprise when greeted with the cost of prescription drugs, the confusion and need of health insurance and the demand for medical history.

Another student was surprised with what she felt were moral judgments being made by her gynecologist. She said she would expect that from an Angolan doctor, but not from an American doctor.

Positive and negative experiences/expectations with U.S. healthcare and providers. Our respondents considered the preventive care practiced by U.S. physicians

to be a positive experience with U.S. healthcare, as well its 24/7 availability. They also praised the treatment and conditions of U.S. hospitals and the availability of all types of medicine as well. One participant added:

"Sometimes you don't feel like you're in a hospital, just in a building waiting for a doctor. I like that, because I hate hospitals," said a 24-year-old male respondent.

The cost of U.S. healthcare was the negative experience to which respondents referred most often. A typical response: "The bills. They were too high for the things they do. I didn't think they would charge that much, because in Angola, they charge you by the problem you have or the things they do to you. Once I was charged $70 by a doctor and I didn't even stay there for five minutes" (24-year-old male respondent).

Different aspects of the medical visit: U.S. vs. Angola. Typically, respondents referred positively to the advanced medical technology available in the U.S. and the fact that they could receive prescriptions or free samples of drugs during the office visit. Apparently, in Angola, physicians phone patients after the visit with the prescription they need. Another participant added:

"We have to go to one pharmacy and sometimes to another pharmacy. They give you free trials here and say, 'Oh, take this for a week,'" said a 27-year-old female respondent.

Respondents also noted that in Angola, physicians are not concerned if a patient misses an appointment [as they are in the United States] because there is always another patient that can be seen instead. However, they praised the fact that in the United States there are available ambulances and emergency rooms, compared to the scarcity of these items in Angola.

Angolan Social Support. International students will often resort to advice and referrals from friends or relatives about health concerns. Patient expectations stem from such relational communication and affect trust, adherence to treatment, and overall satisfaction with the provider.

Preparing a friend or relative coming to the U.S. about what to expect. Respondents said they would warn friends and relatives that U.S. healthcare is very expensive, featuring the need for health insurance and the necessity of filling out many forms. They noted that they would also encourage friends and relatives to bring pills from home to treat certain tropical illnesses with which U.S. healthcare providers have little to no experience. They also recommended bringing a friend to the doctor or hospital to help translate. Some of the comments respondents made were as follows:

"I would tell them don't get sick. It's very different from where we come from, and when one gets to the hospital they will have to fill out some forms and there's nobody to ask questions of" (27-year-old female respondent).

"The first thing is to have health insurance, because here, that's the main point. It's important to have a credit card, too. Also, for a person coming from Angola to here, bring medicines to treat yourself" (24-year-old male respondent).

Discussion

The purpose of this study was to explore perceptions, experiences and expectations of international student/patients in their encounters with American caregivers. Several factors can affect the quality of the encounter in multicultural clinical practices (Gao et al., 2009; Kulwicki, 2006). Previous researchers (Cole, 2002; Heuer, Bengiamim & Downey, 2001; Ulrey & Amason, 2001) mentioned that the greater the class, ethnic, and cultural disparities the more challenging human communication tends to become. Our study revealed that culturally related communication barriers and negative violations of expectations hinder the quality and outcome of the clinical encounter.

Participants emphasized the importance of interpersonal relations in their medical encounters and its connection with perceptions of professional competence in a clinician. The study revealed that patients tend to judge physicians' technical expertise in part by the degree of emotional support and quality of interaction that patients receive. Participants mentioned that friendliness on the part of the provider is a signal that they are dealing with a good doctor or nurse. Therefore, intercultural communication competence from providers is a great asset in college health.

Intercultural communication competence in providers can increase the quality of relational communication between parties. Lack of relational history with the same provider, and rushed clinical encounters so common in U.S. health clinics appear to affect Angolans perceptions of professional competence in providers. Participants implied that this can propitiate challenges in the trust, and satisfaction areas as explained by Balkrishnan and colleagues (2003).

Participants reported as positive expectations the advanced technology in the U.S., effectiveness and quality of medical services managed as a business facility,

availability and abundance of prescribed medicine and samples, rapid rapport with international doctors practicing in the U.S., and emphasis on preventive care.

The most mentioned negative violations of expectations were related to the high cost of medical care and need for insurance and medicine, the complicated insurance system, demand for medical history, short medical encounters which lead to distrust in providers, dissatisfaction with the clinical encounter, existence of gatekeepers that don't let patients talk back with doctors if necessary, the lower chances in the U.S. compared to Angola that the patient will be received by the same doctor if one does not insist upon it, lack of immediacy by the provider, and lack of receptivity and listening by some professionals. These last violations are crucial in this culture because rapport and a relational history with the same provider are very important for this African population. Participants' choice of a certain physician depends on recommendations from family and friends.

In the field of college health, clinicians need to be prepared to recognize symptoms of tropical diseases such as malaria because of the incidence of this disease in several tropical countries represented on campus. Being unfamiliar with common tropical diseases prompts lack of trust, non-adherence, and perceptions of professional and cultural incompetence.

Because of the denial and high stigma placed on mental health, these patients avoided anti-depressants and talking therapies. Their means of venting academic and acculturative stress are restricted in the U.S. because family and previous friendships are no longer available. Demands of cultural and academic adjustment lead to greater risk for psychological problems. This can lead to psychosomatic diseases and non-adherence to medications. University campus health services can propitiate means of fostering extra social support networks for international patients.

Since providers generally have inaccurate perceptions of their patients' expectations (Perron et al. 2003), avoiding negative violations of expectations in clinical interactions could reduce cultural and interpersonal problems in college health. Cultural communication competence appears to contribute to positive health outcomes in these patients.

Limitations

While interpreting the findings, the reader must be cautious to avoid generalizations. First, although the responses of participants provided a wealth of information about the study's population, findings cannot be vastly applied to all sub-Saharan college students in America. Although some countries and population conditions in that area of the African continent may appear similar, because of methodological limitations of a qualitative study the variability of other groups cannot be measured. A second source of limitation comes from a small sample, and from voluntary participation in this convenient sample.

Practical Implications

Information from this study may be useful to clinicians, college health educators, and university counselors working with international students/patients. Clinicians who are educated and motivated to deliver sensitive care will be better equipped to deliver intercultural competent care. Educating health professionals about violations of expectations (both positive and negative) may help in promoting cultural sensitivity, intercultural communication competence, and consequently, prompt higher trust, adherence, and patient satisfaction that ultimately leads to better health outcomes. Providers also need to be aware of a strong stigma in some countries against people who take anti-depressants or seek mental health care.

At international students' orientation, university counselors need to address the different educational levels and specific roles played by nurses in this country, the existence of other allied health professions, the cost and mechanics of health care in the U.S., and the need to understand the health insurance system.

Advisers working at university offices of international students at universities can benefit from the information provided here and knowledge of expectation violation theory. They can incorporate these concepts and potential applications into orientation programs for newcomers and potential international students while still in their country of origin.

Conclusion

In this article we explored perceptions, experiences, and expectations of international students/patients in their encounters with caregivers in America. Understanding patients' culture and worldview helps in the delivery of culturally competent care, and can contribute to positive health outcomes. This study addressed a population of international patients who are originally from one of the most understudied areas in Africa who also became patients within our health care system.

Participants revealed that negative violations of expectations in clinical encounters contribute to delay in seeking medical attention, dissatisfaction, lack of trust in providers, and non-compliance with caregivers' instructions. In addition, the quality of the medical encounter affects patients' perceptions of clinicians' professional competence. Ultimately, information reported here can help providers' ability to work within the cultural context of their patients. We expect that the findings in this study offer further insights to clinicians who work with international patients. Whether the findings of this study are generalizable to intercultural encounters with people of other sub-Saharan nations is an empirical question for future research.

References

Afifi, W. A. & Burgoon, J. K. (2000). Behavioral violations in interactions: The combined consequences of valence and change in uncertainty Interactions outcomes. *Human Communication Research, 26,* 203-233.

Balkrishnan, R., Dugan, E., & Camacho, F.T. (2003). Trust and satisfaction with physicians, insurers, and the medical profession. *Medical Care, 41,* 1058-1064.

Baron, F., Hunter, A., Mayo, R., Willowghby, D. (2004). Acculturation and adherence: Issues for health care providers working with clients of Mexican origin. *Journal of Transcultural Nursing, 15,* 331-337.

Burgoon, J. (1991). Relational message interpretations of touch, conversational distance, and posture. *Journal of Nonverbal Behavior, 15*(4), 233-259.

Burgoon, J., Newton, D., & Walther, J. (1989). Nonverbal expectancy violations and conversational involvement. *Journal of Nonverbal Behavior, 13* (2), 97-119.

Carr, J. L., Koyama, M., & Thiagarajan, M. (2003). A women's support group for Asian international students, *Journal of American College Health, 52* (3), 131-134.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13* (3), 181-184.

Cole, P. (2002). When medicine and culture intersect. *Postgraduate Medicine, 112* (4), 111-115.

Connor, C., Rajkotia, Y., Lin, Y., & Figueiredo (2005). Partners for Health Reform Plus. USAID, United States Agency for International Development. Bethesda: MD. Retrieved from the project website at www.PHRplus.org.

Dennis, R. E., & Giangreco, M.F. (1996). Creating conversation: Reflections on cultural sensitivity in family interviewing. *Exceptional Childhood, 63* (1), 103-116.

Dibben, M. R, & Lean, M. (2003). Achieving compliance in chronic illness management: Illustrations of trust relationships between physicians and nutrition clinic patients. *Health, Risk, and Society, 5* (3), 241-258.

Doescher, M. P., Saver, B. G., Franks, P. & Fiscella, K. (2000). Racial and ethnic disparities in perceptions of physician style and trust. *Archives of Family Medicine,* 9 (10), 1156-1163.

Du Pre, A. (2004). *Communicating about health: Current issues and perspectives* (2nd ed.). Boston: McGraw-Hill.

Gao, G., Burke, N., Somkin, C. P., & Pasick, R. (2009). Considering culture inphysician-patient communication during colorectal cancer screening. *Qualitative Health Research*. April 10 [Epub ahead of print].

Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine Press.

Griffin, E. (2000). *A first look at communication theory*. Boston McGraw-Hill.

Halley, B.J., Pargeon, K., & Crawford, V. (2000). Can healthcare providers at a university health clinic predict patient satisfaction? *Journal of American College Health, 49* (3), 111-118.

Heuer, L. Bengiamin, M., & Downey, V. (2001). The impact of an international cultural experience on previously held stereotypes by American student nurses. *Multicultural Education*. Accessed May 8, 2009, from www.findarticles.com/p/articles/mi_qa3935/is_200110/ai_n8960443/pg7.

Juon, H. S., Kim, M., Shankar, S., & Han, W. (2004). Predictors of adherence to screening mammography among Korean American women. *Preventive Medicine, 39* (3), 474-481.

Kravitz, R. L. (2001). Measuring patients' expectations and requests. *Annals of Internal Medicine, 134*, 881-888.

Kreps, G. L., & Thornton, B.C. (1992). *Health Communication: Theory & Practice* (2nd ed.). Prospect Heights, IL: Waveland Press.

Kulwicki, A. (2006). Improving global health care through diversity. *Journal of Transcultural Nursing, 17* (4), 396-397.

Manusov, V., & Hegde, R. (1993). Communicative outcomes of stereotype-based expectancies: An observational study of cross-cultural dyads. *Communication Quarterly, 41*(3), 338-354.

Moore, J.L. & Constantine, M.G. (2005). Development and initial validation of the collectivistic coping styles measure with African, Asian and Latin American international students. *Journal of Mental Health Counseling, 27*(4), 329-347.

Mori, S. (2000). Addressing the mental health concerns of international students. *Journal of Counseling & Development, 78* (2), 137-144.

Ndiwane, A., Miller, K. H., & Bonner, A. et al. (2004). Enhancing cultural competencies of advanced practice nurses: Health care challenges in the twenty-first century. *Journal of Cultural Diversity, 11*, 118-121.

Norton, D. (2000). Tuberculosis screening for international students. *Journal of American College Health, 48* (4), 187-190.

Open Doors Online. Report on International Educational Exchange, November 2008. Available at http://opendoors.iienetwork.org/ Retrieved on 3/3/2009.

Perron, N. J., Secretan, F., Vannotti, M. Pecoud, A., & Favrat, B. (2003). Patient expectations at a multicultural outpatient clinic in Switzerland. *Family Practice, 20*(4), 428-433.

Seid, M. (2008). Barriers to care and primary care for vulnerable children with asthma. *Pediatrics, 122*(5), 994-1002.

Seidman, I. (2005). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*, (3rd edition.). New York: Teachers College.

Spitzberg, B. H. & Cupah, W. R. (1989). *Handbook of interpersonal competence research.* New York: Springer Verlog.

Spitzberg, B. H. (1997a). A model of intercultural competence. In L. A. Samovar & R.E. Porter (eds.) *Intercultural Communication: A reader* (8th ed., pp. 379-391). Belmont, CA: Wadsworth.

Spitzberg, B. H. (2000b). A model of intercultural communication competence. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural Communication: A Reader* (9th ed.) (pp. 375-385). Belmont, CA: Wadsworth.

Sun, A., Zhang, J., Tsoh, J., Wong-Kim, E., Chow, E. (2007). The effectiveness in utilizing Chinese media to promote breast health among Chinese women. *Journal of Health Communication, 12*, 157-171.

Ulrey, K. L., & Amason, P. (2001). Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. *Health Communication, 13*, 449-463.

Unger, J. B., & Molina, G. B. (2000). Acculturation and attitudes about contraceptive use among Latina women. *Family Planning Perspectives, 21* (3), 235-249.

U.S. Census Bureau, (2005). 2005 American community survey data: Race and ethnicity. Retrieved February 21, 2007, from www.factfinder.census.gov. Wiseman, R. L., Hammer, M.R., & Nishida, H. (1989). Predictors of intercultural communication competence. *International of Intercultural Relations, 13*, 349-370.

Wright, K. B., Sparks, L., O'Hair, D. (2008). *Health communication in the 21st century*. Blackwell Publishing: Malden, MA.

Van Servebellen, G. M. (2009). *Communication skills for the health care professional: Concepts, practice, and evidence* (2nd ed.). Jones & Barlett Publishers.

Yu, M. Y. Hong, O. S. & Seeto, A. D. (2003). Uncovering factors contributing to under-utilization of breast cancer screening by Chinese and Korean women living in the United States, *Ethnicity and Disease, 13* (2), 213-219.

Zemencuk J. K., Hayward, R. A., Skarupski, K. A., Katz, S. J. (1999). Patients' desires and expectations for medical care: A challenge for improving patient satisfaction. *American Journal of Medical Quality, 14* (1), 21-27.

Appendix

Research Protocol

Demographics
Sex
Age
Major
How long have you been in the U.S?

1. How many times have you visited the doctor in the U.S.? Specialties?

2. I'm going to describe the main steps in the doctor patient encounter.
   Tell me what is different in Angola.

3. In your opinion, what makes a good doctor? And a good nurse?

4. What makes you trust a doctor? Nurse?

5. What makes you to be satisfied with a doctor? Nurse?

6. Do you always do exactly what the doctor prescribes? Why or why not?

7. What personal characteristics of the doctor make you do what they tell you?
   For example: take your medicine, follow medical regimens, etc

8. What comes first, trust or satisfaction? Can you trust without satisfaction? Can you be satisfied without trust?

9. What surprised you the most in your first medial encounter in the U.S.?

10. Please tell me both positive and negative surprises/experiences.

11. What other aspects of the medical visit in Angola are very different than the visits in the U.S.

12. How would you prepare or advise a friend or relative about to come to the U.S. regarding what to expect in the medical field?

Received: September 30th, 2009

Revision Received: December 10th, 2009

Accepted: December 30th, 2009