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Cultural Competence in Medical Tourism: Applying Communication Accommodation Theory to Improve Doctor-Patient Communication and Medical Tourism Prospects in India

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Abstract *The exponential growth of the medical tourism industry, particularly in India, has highlighted the importance of effective communication between healthcare providers and international patients. This study explores the role of Communication Accommodation Theory (CAT) in enhancing doctor-patient communication in the Indian medical tourism sector, focusing on cultural competence and its impact on patient experiences. A cross-sectional study was conducted with a sample of 1,476 international patients at a healthcare institution in Delhi. Data were collected using a comprehensive questionnaire designed to capture cross-cultural communication nuances. The study employed a post-positivist research approach, and data were analysed using SPSSv24, Smart PLS 3, and MGA-PLS to examine the relationships between various communication-related factors and patient experiences. The analysis revealed that patients' subjective beliefs and expectations about healthcare or medical tourism significantly influence their healthcare experiences. A strong positive relationship (path coefficient = 0.809) was found between subjective beliefs and patient experience, indicating that culturally competent communication leads to better outcomes. The study also found that patient expectations mediated the relationship between subjective beliefs and patient experiences, emphasizing the need for healthcare providers to manage and meet these expectations effectively. The results underscored the importance of cultural sensitivity in medical communication, particularly regarding gender norms, non-verbal cues, and communication styles.*

Keywords: *Medical Tourism, Communication Accommodation Theory, Cultural Competence, Doctor-Patient Communication, India*

INTRODUCTION

Medical tourism industry has witnessed exponential growth over the past few decades. It involves patients traveling across borders to seek medical treatments that may not be available, affordable, or timely in their home countries. India has emerged as a leading destination in this global industry, with its advanced healthcare infrastructure, highly trained medical professionals, and cost-effective treatment options. According to the Ministry of Tourism, Government of India, the country received 728,000 medical tourists in 2024 (data till August 2024) up from 697,453 medical tourists in 2019. While the quality of clinical care is undoubtedly critical to the success of medical tourism, another equally vital factor is the communication style between healthcare providers and international patients. The effectiveness of this communication often hinges on the providers' ability to navigate and respect cultural differences, making it a crucial element in ensuring a positive patient experience.

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In medical tourism, communication styles play a pivotal role in bridging the cultural gap between healthcare providers and patients from diverse backgrounds. Effective communication in healthcare is not merely about the exchange of medical information but also about understanding and respecting the cultural nuances that influence how patients perceive and respond to care. According to Hall (2016), communication styles can be broadly categorized into high-context and low-context cultures. High-context cultures, which are common in many Asian and Middle Eastern societies, rely heavily on non-verbal cues, context, and indirect communication. Conversely, low-context cultures, prevalent in Western countries, value direct, explicit communication and clear instructions.

The implications of these communication styles are profound in medical tourism. For instance, a healthcare provider from a low-context culture may prioritize straightforward communication, expecting patients to appreciate clear and direct instructions. However, a patient from a high-context culture might perceive such directness as blunt or disrespectful, preferring instead a more nuanced approach that considers their unspoken concerns and the broader context of their situation. Failure to recognize and adapt to these differences can lead to misunderstandings, dissatisfaction, and even non-compliance with medical advice (Betancourt et al., 2016).

In conservative Islamic countries, for example, communication is indirect with strict norms regarding physical contact between unrelated men and women. A medical professional who is unaware of these cultural norms might inadvertently offend a patient by offering handshake or initiating physical contact without permission. In such contexts, it is crucial for healthcare providers to be attuned to non-verbal cues and to follow the patient's lead when it comes to physical contact, ensuring that their communication respects cultural sensitivities (Ali et al., 2017). In contrast, patients from non-conservative African cultures may exhibit more relaxed attitudes towards physical contact, with handshakes and even hugs being common forms of greeting (Nwoye, 2015). Healthcare providers who are rigidly adhering to their own cultural norms without considering the patient's cultural background might come across as distant or unapproachable. Thus, understanding and adapting to these diverse greeting styles can significantly enhance the rapport between healthcare providers and patients, fostering a more comfortable and trusting environment.

Purnell (2018) emphasizes that culturally informed communication is not only about language proficiency but also about understanding the subtleties of non-verbal communication, which are often deeply rooted in cultural practices. For example, in some cultures, maintaining eye contact is a sign of confidence and sincerity, while in others, it might be interpreted as disrespectful or confrontational. Healthcare providers in the medical tourism industry must be trained to recognize these differences and adjust their communication style accordingly.

Healthcare providers need to be aware of gender-based preferences of their cross border and overseas patients. Patients from conservative cultures, particularly in the Middle East and South Asia prefer to be examined by healthcare providers of the same gender due to religious or cultural reasons (Hasnain et al., 2017). In contrast, such preferences may be less pronounced in more liberal societies where gender roles are less strictly defined. When healthcare providers accommodate to the patient preferences, it helps in building trust and ensuring that patients feel respected and comfortable.

As patients travel across borders for medical treatment, they bring with them not only their medical needs but also their cultural identities and expectations. The effectiveness of communication in the medical tourism industry, therefore, is also influenced by the broader cultural beliefs about health, illness, and treatment that patients bring with them. Some cultures may have a strong preference for traditional or holistic approaches to healing, which might conflict with the modern, evidence-based medical practices commonly used in host countries. Betancourt et al. (2016) argue that healthcare providers who are trained in cultural competence are better equipped to negotiate these differences, offering care that aligns with the patient's cultural expectations while still adhering to best medical practices. This approach not only improves patient satisfaction but also promotes better health outcomes by encouraging adherence to treatment plans.

The Indian government's initiatives to promote medical tourism, such as the introduction of e-medical visas and the establishment of medical tourism boards, have further supported the industry's growth (Sharma & Jindal, 2019). However, the success of these initiatives depends not only on the availability of high-quality medical services but also on the ability of healthcare providers to communicate effectively with a culturally diverse patient population.

Despite the growing body of literature on medical tourism, there remains a need for further research into the role of communication in patient experiences. There remains a gap regarding the way manner in which cultural accommodation or lack of it hampers patient experiences, important for patient satisfaction, and recommendations. Anchored on the Communication Accommodation Theory (CAT) our research aims to understand the communication and culture related beliefs and expectations of cross border and overseas patients and how these influenced their experiences in the clinical interactions in a NABH & JCI approved hospital Delhi, India. Understanding which verbal and non-verbal accommodations are most impactful for diverse patient populations could enhance the practical application of

CAT in real-world settings. When healthcare providers in India engage in communication accommodation, it leads to improved patient experiences and higher levels of satisfaction in hospitals catering to international patients (Gupta & Das, 2018; Singh & Singh, 2019; Mukherjee, 2017). We hypothesised that there would be differences in the beliefs, expectations, and experiences of the western and non-western patients; that the relationship may be moderated by waiting time and consulting time and that unmet expectations depend on the beliefs of patients and influence the experiences.

LITERATURE REVIEW

Communication Accommodation Theory

The rapid growth of the global medical tourism industry has brought significant attention to the dynamics of doctor-patient relationships, particularly in the context of cross-cultural interactions. India has established itself as a premier hub for medical tourism, attracting patients from various cultural backgrounds due to its advanced healthcare infrastructure, skilled medical professionals, and cost-effective treatment options. In this evolving landscape, communication accommodation theory (CAT) offers a valuable framework for understanding and enhancing the communication between healthcare providers and international patients.

Originally developed by Howard Giles, CAT explores how individuals adjust their communication styles to align with or differentiate from others, thereby influencing the quality of interpersonal interactions. Communication accommodation theory provides insights into how doctors can adapt their communication styles to improve patient satisfaction and trust, thereby enhancing the overall medical tourism experience.

CAT posits that individuals adjust their communication behaviours in response to the perceived needs, preferences, and cultural backgrounds of their interlocutors (Giles, 2016). In the context of medical tourism, this theory can be applied to understand how healthcare providers might modify their verbal and non-verbal communication strategies to better align with the expectations of international patients. For example, a healthcare provider in India might use more formal language, reduce the use of medical jargon, or employ culturally relevant metaphors when interacting with patients from different linguistic or cultural backgrounds. These adjustments, or "accommodations," can help bridge communication gaps, making patients feel more understood and respected (Gasiorek & Giles, 2015).

India's diverse patient population, which includes individuals from the Middle East, Africa, and South Asia, presents unique challenges and opportunities for applying CAT. Mittal et al. (2019) noted that patients from these regions often have distinct cultural expectations regarding communication styles. For instance, patients from high-context cultures, where communication is often implicit and relies heavily on non-verbal cues, may prefer a more indirect and respectful form of communication. Conversely, patients from low-context cultures, which favour direct and explicit communication, may appreciate clarity and straightforwardness in their interactions with healthcare providers. CAT suggests that by recognizing and adapting to these preferences, doctors can foster stronger relationships with their international patients.

The application of CAT in medical tourism also involves adjusting non-verbal communication behaviours. Non-verbal cues, such as eye contact, gestures, and physical proximity, play a significant role in doctor-patient interactions, especially in cross-cultural settings. For example, maintaining eye contact might be interpreted as a sign of confidence and sincerity in some cultures, while in others, it could be seen as confrontational or disrespectful (Gudykunst & Kim, 2017). Healthcare providers, aware of these cultural differences, can use non-verbal accommodations to create a more comfortable and trusting environment for their patients. This aspect of CAT is particularly relevant in India, where the patient demographic is highly varied, and understanding these nuances can greatly impact the success of medical tourism efforts.

In addition to verbal and non-verbal communication, CAT emphasizes the importance of convergence and divergence in interactions. Convergence occurs when individuals adapt their communication style to be more similar to their interlocutor, thereby enhancing social bonds and mutual understanding. In the medical tourism context, convergence might involve a doctor adopting certain linguistic patterns or social norms that are familiar to the patient, thereby reducing the perceived social distance (Giles & Ogay, 2007). For instance, a healthcare provider might learn basic phrases in the patient's native language or adopt culturally specific greetings to demonstrate respect and cultural awareness. Such efforts can significantly enhance the doctor-patient relationship, leading to higher patient satisfaction and trust.

Conversely, divergence occurs when individuals emphasize the differences between their communication style and that of their interlocutor, which can sometimes be necessary to assert professional authority or clarify roles within the doctor-patient dynamic (Soliz & Giles, 2014; Dogra & Dogra, 2017, p. 325). In the context of medical tourism, divergence might be employed by healthcare providers to maintain clarity and assert the importance of adhering to medical advice, particularly when cultural beliefs might conflict with medical practices. For example, a doctor might need to clearly articulate the importance of evidence-based medicine when interacting with patients who have

strong beliefs in traditional or alternative therapies. By carefully balancing convergence and divergence, healthcare providers can navigate the complexities of cross-cultural communication while maintaining effective and respectful interactions with their patients.

The application of communication accommodation theory offers valuable insights into how healthcare providers can enhance doctor-patient relationships in the international medical tourism industry. By understanding and adapting to the communication preferences of international patients, healthcare providers can create a more inclusive and supportive environment that fosters trust and satisfaction. As medical tourism continues to grow, particularly in culturally diverse hubs like ours, the ability to effectively apply CAT will become increasingly important for healthcare providers seeking to deliver culturally competent care that meets the needs of a global patient population.

The success of medical tourism heavily relies on effective communication, which directly influences patient satisfaction, trust, and adherence to medical advice (Smith et al., 2016). Research indicates that communication barriers are a major source of dissatisfaction among medical tourists, highlighting the need for targeted training programs that incorporate CAT principles (Berwick, 2016). Miscommunication, particularly when rooted in cultural differences, can lead to significant misunderstandings, diminished patient satisfaction, and even compromised care quality. CAT provides a framework to address these issues by advocating for the adjustment of communication styles to better align with the cultural and linguistic preferences of patients. Studies emphasize the importance of healthcare providers developing skills in cultural competence and communication accommodation to navigate these challenges effectively (Beach et al., 2017).

In India, there is growing recognition of the need for communication accommodation training for medical professionals, particularly in the context of the medical tourism industry. Such training focuses on equipping healthcare providers with the skills needed to adjust their communication styles in ways that respect and align with the cultural backgrounds of their patients (Betancourt et al., 2017). Programs grounded in CAT principles cover essential topics such as cultural awareness, sensitivity in clinical practices, and effective verbal and non-verbal communication strategies that are culturally adaptive (Saha et al., 2018). Studies suggest that these training programs can significantly enhance patient satisfaction and outcomes within the medical tourism sector (Goel & Goel, 2020).

Grounded in post-positivist epistemology, our study proposed to examine the following hypotheses:

H1: There is a significant relationship between the use of high-context or low-context communication styles and patient satisfaction in the context of medical tourism in India.

H2: Cultural sensitivity in communication has a significant positive impact on patient experience in the context of medical tourism in India.

METHODOLOGY AND DATA COLLECTION

Sample and Analysis

This cross-sectional study adopted convenience sampling technique to select participants at a single JCI & NABH recognised healthcare institution in Delhi. The final sample size was 1,476 patients. The participants represented a diverse group of patients from 34 different countries, ensuring a broad and comprehensive understanding of the varied cross-cultural communication experiences (Table 1).

Table 1: Demographic Profile of the MT Patients

Demographic Category	Group 1	Group 2	Group 3	Group 4
Gender	Male	Female		
	832	642		
Geography	Western	Non-western		
	89	1385		
World bank classification of Economy of the coutry	Low	Middle	Upper	
	1003	347	124	
Severity of ailment	Less complicated	Moderately complicated	Highly complicated	
	473	589	412	
Satisfaction with Consultation time	Low	Moderate	High	
	347	147	980	

Demographic Category	Group 1	Group 2	Group 3	Group 4
Average Waiting time in minutes	Less than 5	6-10	11-15	Above 15 minutes
	403	510	427	134
Final decision to opt for treatment in the hospital after first few clinical encounters	Not opted	Opted		
	83	1391		

Data were collected using a detailed questionnaire specifically designed to capture the nuances of cross-cultural communication between doctors and patients. To facilitate a detailed assessment, the questionnaire utilized a scale ranging from 1 to 10, which allowed for a nuanced evaluation of patient perceptions and experiences. The questionnaire consisted of six primary questions, further divided into 71 sub-questions to investigate key aspects of cross-cultural communication, including verbal and non-verbal communication, language barriers, body language, cultural norms, time orientation, and the dynamics of linear vs non-linear cross-cultural communication styles. In particular, the questionnaire focused on exploring the balance between directness and indirectness, formality and informality, and hierarchical versus egalitarian communication approaches in doctor-patient interactions.

Data analysis was conducted using Smart SPSSv24, PLS 3.0 & MGA-PLS. The Common method variance (CMV) by Harman's single factor test confirmed that the total variance extracted by one factor was 25.34%, below the recommended threshold of 50%.

RESULTS AND ANALYSIS

Phase One (SPSS)

Descriptive statistics such as mean, median, standard deviation, skewness, and kurtosis were within acceptable ranges, indicating a normal distribution of the data. First, an Exploratory Factor Analysis (EFA) was conducted using the Principal Components Analysis method for each of the three hypothesised constructs: Patients beliefs regarding the quality of MT intercultural communication (ICC) in the hospital, MT patient ICC expectations, and MT patients ICC experiences in the clinical interactions during their stay. The construct, MT patient ICC beliefs regarding the Indian MT hospital was compressed to three factors: ICC beliefs regarding *country and culture*, ICC beliefs regarding the *cultural accommodation* by the hospital team, and cognitive ICC beliefs related to *treatment* in the hospital.

Table 2: EFA: MT Patient ICC Beliefs Regarding the Indian MT Hospital

Sn	Rotated Component Matrix[a]			
	ICC related beliefs of MT patients regarding the Indian MT hospital	**Component/ Factor**		
		ICC beliefs regarding the country and culture	**ICC beliefs regarding the Cultural accommodation by the hospital**	**Cognitive ICC beliefs related to treatment in the hospital**
1	I am aware of health risks in new country	.779		
2	I believe that Indian hospitals are sensitive to patient concerns	.742		
3	I believe that cultural disparities are accounted for in the hospital	.666		
4	I am conscious about doctor's gender	.644		
5	I believe I am knowledgeable about the characteristics of treating hospital	.614		
6	I believe that the medical record language is amenable to my culture		.815	
7	I am knowledgeable about traditional healing systems/cultures		.680	
8	India is a reliable MT hub		.644	
9	I believe that the doctors in the treating hospital have received cross-cultural training		.563	
10	I believe that the Indian doctors are knowledgeable about cultural differences			.834
11	I believe that the doctors are flexible to appreciate my specific treatment concerns			.582
12	I believe treatment cost can be discussed			.580
	Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.			
	Rotation converged in 8 iterations. Total variance explained=58.700			

The EFA on experience resulted in four factors viz., expressive communication behaviour, receptive communication behaviour, communication accommodation, code switching behaviour.

Table 3: EFA: MT Patient ICC Related Experiences

	Rotated Component Matrix[a]				
1	**The hospital /attending team of physicians/Items**	**Communication accommodation**	**Receptive communication behaviours**	**Code switching**	**Expressive communication behaviour**
		1	2	3	4
2	appointed a language translator	.815			
3	Was adept in handling queries	.680			
4	educated me about medical issue	.653			
5	advised change in health behaviours	.647			
6	showed concern	.589			
7	made eye contact	.585			
8	performed a culturally sensitive PE	.584			
9	dealt confidently with questions		.773		
10	Identified unexpressed cultural ICC beliefs		.762		
11	made cultural gaffes		.721		
12	prescribed/negotiated a culturally sensitive treatment plan				
13	listened to me				
14	engaged in small talk			.867	
15	explained problem in my language			.814	
16	apologised for these cultural gaffes				.828
17	demonstrated knowledge about cultural expressions of pain				.558
	Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.				
	a. Rotation converged in 6 iterations. Total variance explained: 61.041				

The EFA for expectations (mediator) resulted in four factors viz., expressive communication skills, receptive communication style, and cultural sensitivity in medical processes (Tables 2, 3, and 4).

Table 4: EFA: MT Patients' Expectations (Hypothesised Mediator)

Sn.	**ICC expectations from the hospital /attending team of physicians**	**Expressive communication skills**	**Cultural sensitivity in medical process**	**Receptive communication style**
1	talk clearly with patients	.764		
2	advise changes as per culture	.764		
3	adeptness in handling queries	.760		
4	apologies for cultural gaffes	.674		
5	deal with my questions	.671		
6	appear informal and relaxed	.655		
7	be direct and speak plainly	.653		
8	translators	.652		
9	culturally sensitive treatment plan to be drawn		.768	
10	perform culturally sensitive PE		.742	
11	listening and responsive			.754
12	eye contact			.719
	Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization.			
	a. Rotation converged in 6 iterations. Total variance explained: 58.078			

Phase Two: Smart PLS 3.0

The relationship between the three EFA factors related to subjective beliefs of the MT patients, four EFA factors related to the MT ICC experience, and three EFA factors related to the MT patients ICC expectations (mediator variable) were tested using the Confirmatory Factor Analysis (CFA) using the Smart PLS 3.0. Only one factor in each of the hypothesised constructs was found to have significant effects in the proposed model: Subjective beliefs of the MT patients regarding the *'Country and culture in an Indian hospital'*; experience with the '*communication accommodation demonstrated by the attending team in the host country hospital'*; and Expectation of '*receptive*

communication behaviours (listening, eye contact, show of concern through appropriate body language) by the host country doctors'

The data analysis using smart PLS 3.0 revealed a significant path coefficient between subjective beliefs and patient experience, indicating a strong positive relationship. This suggests that patients with higher subjective beliefs —those who felt more confident in their interactions with culturally competent doctors—had better overall experiences. This finding supports the central tenet of CAT, which posits that when communication is adjusted to meet the needs of the interlocutor, it leads to more positive outcomes.

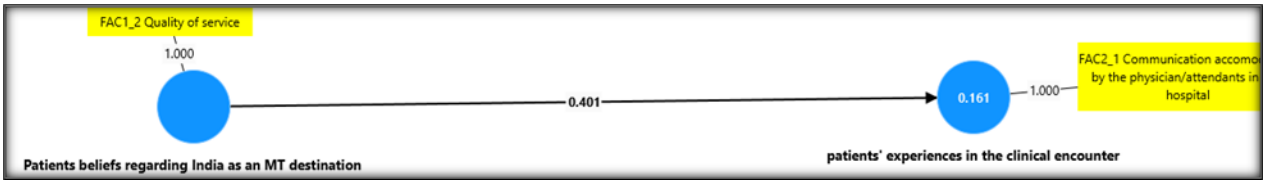


Fig. 1: Result of the CFA Analysis Showing the Relationship between MT Patient' Subjective ICC Beliefs Regarding Indian Hospital' and Patient Experience Regarding the Communication Accommodation by the Hospital Team

The constructs in the study demonstrated strong convergent validity, with high loadings on their respective indicators. This means that the measured items were highly representative of the underlying constructs they were intended to assess. Cronbach's Alpha for the constructs was 0.809, while composite reliability values for subjective beliefs were 0.823 (rho_a) and 0.874 (rho_c), indicating high internal consistency. The Average Variance Extracted (AVE) was 0.635, further confirming good convergent validity. These metrics collectively ensure that the constructs were reliably measured and accurately captured the theoretical concepts of interest. Discriminant validity was assessed using the Heterotrait-Monotrait (HTMT) ratio, with a value of 0.659 for subjective beliefs and patient experience, indicating that the constructs were sufficiently distinct from one another.

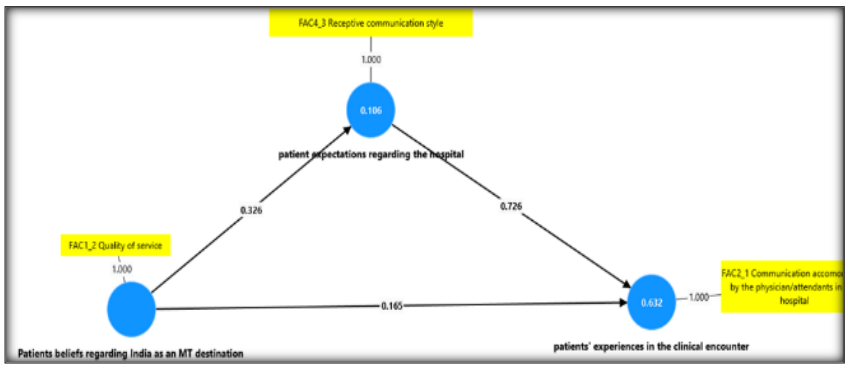
Partial mediation by patients' expectations was indicated (the path coefficient decreased from 0.401 to 0.165). The R square increased to 0.631 post the addition of the mediator variable (expectations regarding the receptiveness of the Indian medical team.

Structural Model: Bootstrapping for N=10,000 samples, the results showed that the T statistics were above the recommended cut-off indicating the relevance of the model. The p-values were found to be significant.

Table 5

	Original sample (O)	Sample mean (M)	Standard deviation (STDEV)	T statistics (|O/STDEV|)	P values
Patient beliefs regarding India as an MT destination -> patient expectations regarding the hospital	0.326	0.326	0.026	12.517	0.000
Patient beliefs regarding India as an MT destination -> patients' experiences in the clinical encounter	0.165	0.165	0.019	8.803	0.000
Patient expectations regarding the hospital -> patients' experiences in the clinical encounter	0.726	0.725	0.013	53.879	0.000

The Blindfolding tests showed the Q^2 value was positive (Q^2 = 0.159) indicating predictive relevance of the model. The final research model is presented in Figure.



Source: Smart PLS

Fig. 2: Final Research Model After Adding the Mediator Variable

Moderating variables such as average waiting time and requests for additional consultations further improved the explanatory power of the model, increasing the R-square value for patient experience from 0.380 to 0.417. The control variables also had significant interaction effects with subjective beliefs, indicating that they played a role in influencing patient experiences. Despite these interactions, the direct effects of subjective beliefs on patient expectations and experiences remained robust and significant, underscoring the strength of these relationships even when accounting for other factors.

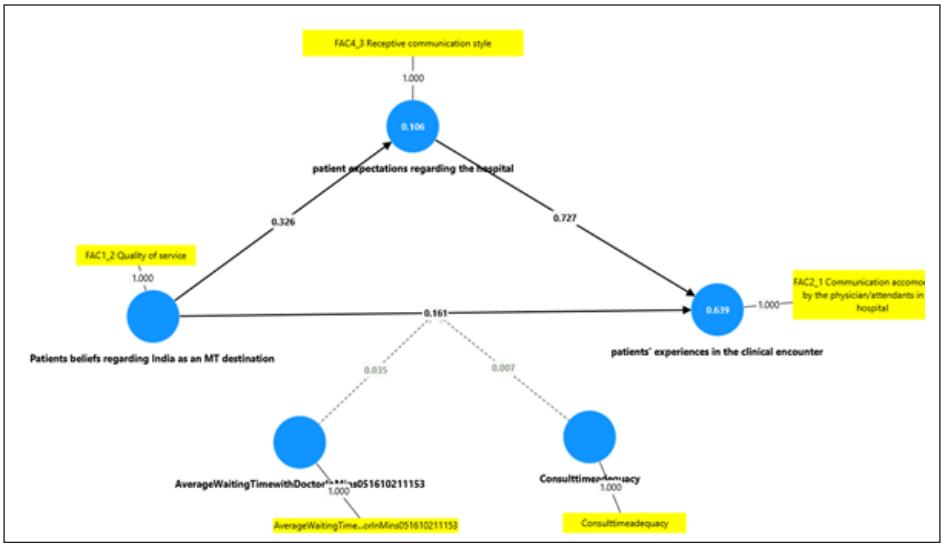


Fig. 3: Effects of the Moderator Variables on the Model

DISCUSSION

The findings of this study underscore the pivotal role of effective communication in shaping the experiences of international medical patients, particularly in the context of medical tourism in India. The statistical analysis highlights that patients' subjective beliefs and expectations significantly influence their healthcare experiences. Specifically, the mediation effect of patient expectations on the relationship between subjective beliefs and patient experiences suggests that healthcare providers must not only focus on enhancing patient confidence but also on effectively managing and meeting these expectations. This discussion explores how Communication Accommodation Theory (CAT) can be applied to improve doctor-patient communication, thereby enhancing patient experiences and boosting the success of international medical tourism in India.

Communication Accommodation Theory (CAT), developed by Howard Giles, provides a robust framework for understanding how healthcare providers can adapt their communication styles to better meet the needs of international patients. CAT posits that individuals adjust their communication behaviours—either converging towards or diverging from the communication style of their interlocutors—to facilitate understanding, build rapport, and achieve communicative goals. In the context of international medical tourism, where patients often come from diverse cultural backgrounds, the ability of doctors to accommodate their communication styles to align with the cultural expectations of patients is crucial for ensuring positive healthcare experiences.

Patients' cultural and religious beliefs significantly shape their perceptions of medical treatment, particularly when they travel to foreign countries for healthcare. The study's findings align with the broader literature, indicating that when patients perceive their cultural beliefs are respected and integrated into their care, they are more likely to have positive treatment experiences and outcomes. For example, addressing a patient's religious practices, such as prayer times or dietary restrictions, can reduce anxiety, enhance adherence to treatment plans, and improve overall satisfaction.

In applying CAT, healthcare providers can adopt a convergent communication style to better align with the cultural norms of their patients. For instance, doctors treating patients from Middle Eastern cultures may adopt a more gender-sensitive approach by ensuring that female patients are examined by female doctors, respecting cultural norms around gender interactions. Similarly, in many Asian cultures where modesty is highly valued, doctors can demonstrate cultural sensitivity by being mindful of how they conduct physical examinations, thereby fostering a sense of respect and comfort for the patient.

Understanding the distinction between linear and non-linear communication is critical for effective cross-cultural healthcare delivery. Well-known frameworks such as the low context-high context framework by Edward Hall, the Trompenaars framework, the Hofstede framework, and the Lewis framework can be referred for training the medical team attending to the intercultural medical tourists.

In high-context cultures, doctors must be particularly attuned to non-verbal signals, such as body language and tone of voice, to fully understand the concerns of their patients. For example, a patient may not directly express discomfort or dissatisfaction, but their non-verbal cues may indicate unease. In such cases, adopting a convergent communication style by paying close attention to these subtle cues can help healthcare providers better address patient concerns and enhance their overall experience.

On the other hand, when dealing with patients from low-context cultures, healthcare providers should prioritize clarity and directness in their communication. Detailed explanations and explicit instructions are valued in these settings, as they help prevent misunderstandings and ensure that patients fully comprehend their medical conditions and treatment plans. By adapting their communication style to match the cultural context of the patient, healthcare providers can improve patient satisfaction and adherence to medical advice.

CAT emphasizes two key strategies in communication: convergence and divergence. Convergence involves adapting one's communication style to be more similar to that of the patient, which can foster a sense of familiarity and trust. For example, when treating a patient from a collectivist culture, where family involvement in medical decisions is important, a doctor might emphasize the role of the family in the treatment process, thereby aligning with the patient's cultural values.

Divergence, on the other hand, involves maintaining a distinct communication style, which may be necessary to assert professional authority or clarify medical protocols. For instance, in situations where a patient's cultural beliefs might conflict with evidence-based medical practices, a doctor may need to adopt a more authoritative communication style to ensure that the patient understands the importance of following the prescribed treatment plan. By strategically employing convergence and divergence, healthcare providers can navigate the complexities of cross-cultural communication, ensuring both respect for the patient's cultural values and adherence to medical best practices.

Non-verbal communication plays a significant role in doctor-patient interactions, especially in cross-cultural contexts. Gestures, facial expressions, eye contact, and body language are powerful tools that can convey empathy, respect, and understanding. However, the interpretation of these non-verbal cues can vary widely across cultures.

For example, maintaining eye contact is generally perceived as a sign of confidence and attentiveness in Western cultures, but in many Asian cultures, it may be seen as disrespectful or confrontational. Similarly, a warm smile might be universally appreciated, but the appropriateness of physical gestures such as touching a patient's shoulder can differ depending on cultural norms. Healthcare providers who are aware of these cultural differences and adapt their non-verbal communication accordingly are more likely to build trust and rapport with their patients, leading to better healthcare outcomes.

To effectively implement CAT in the healthcare setting, cross-cultural training for healthcare providers is essential. As India continues to emerge as a leading destination for medical tourism, it is imperative that healthcare providers are equipped with the skills to understand and respect these cultural differences. Cross-cultural training programs should focus on educating healthcare providers about different communication styles, cultural norms, and health-related beliefs and practices.

Such training can significantly enhance the ability of healthcare providers to accommodate their communication styles to meet the needs of international patients. For instance, training on high-context and low-context communication can help doctors recognize when to use more implicit versus explicit communication strategies. Additionally, training on non-verbal communication can prepare healthcare providers to use gestures and body language effectively in a culturally sensitive manner.

The successful application of CAT in improving doctor-patient communication has significant implications for the Indian medical tourism industry. By fostering culturally competent communication, Indian healthcare providers can enhance the overall patient experience, leading to higher levels of patient satisfaction and loyalty. This, in turn, can attract more international patients to seek treatment in India, bolstering the country's reputation as a premier destination for medical tourism.

Moreover, as international patients share their positive experiences with others, word-of-mouth recommendations can further strengthen India's position in the global medical tourism market. To sustain this growth, it is crucial for Indian healthcare institutions to invest in ongoing cross-cultural training for their staff, ensuring that they remain adept at accommodating the diverse communication needs of their international patients.

The application of Communication Accommodation Theory offers a valuable framework for improving doctor-patient

communication in the context of international medical tourism. By understanding and adapting to the cultural and communicative preferences of international patients, healthcare providers can significantly enhance patient experiences, leading to better healthcare outcomes and increased patient satisfaction. As India continues to grow as a hub for medical tourism, the implementation of CAT in healthcare settings will be essential for maintaining high standards of patient care and strengthening the country's position in the global market.

Based on the outcome of this study, these are few recommendations for Improving Doctor-Patient Communication in India to Promote International Medical Tourism. Firstly, healthcare providers in India should undergo comprehensive cross-cultural communication training that incorporates the principles of Communication Accommodation Theory (CAT). These programs should educate doctors on the cultural norms, values, and communication styles of the diverse international patient populations they serve. By understanding these differences, doctors can better accommodate their communication to align with the expectations and preferences of patients from various cultural backgrounds, thereby enhancing patient satisfaction and outcomes. Secondly, Doctors should be trained to adopt flexible communication strategies that can be adjusted based on the cultural context of the patient. This includes recognizing when to use convergent communication—where the doctor adapts their style to align with the patient's cultural norms—and when to use divergent communication to maintain professional boundaries or assert medical authority. This adaptability is crucial in ensuring that the communication is effective and culturally appropriate, fostering a positive healthcare experience for international patients. Indian healthcare providers should be trained to interpret and utilize non-verbal cues such as eye contact, facial expressions, gestures, and body language in ways that are culturally sensitive. Understanding the cultural significance of these cues can help doctors build trust and rapport with international patients, making them feel respected and understood. For example, doctors should be aware that maintaining eye contact may be perceived differently across cultures, and adjust their behaviour accordingly. Doctors should be mindful of cultural sensitivities during medical examinations, particularly regarding gender norms and modesty. For instance, in cultures where female patients may prefer to be examined by female doctors, healthcare facilities should ensure that such options are available. Additionally, doctors should be trained to conduct examinations in a manner that respects the patient's cultural and religious beliefs, thereby enhancing their comfort and trust in the healthcare system. Also, in low-context cultures, where explicit and direct communication is valued, doctors should focus on providing clear, detailed, and straightforward explanations about medical conditions and treatment plans. This approach helps prevent misunderstandings and ensures that patients fully understand their medical care. Tailoring communication to match the patient's cultural expectations not only improves comprehension but also fosters a sense of confidence and trust in the healthcare provider.

Healthcare providers should make a concerted effort to incorporate patients' cultural preferences into their care plans. This can include accommodating dietary restrictions, respecting prayer times, and considering family involvement in medical decisions, particularly for patients from collectivist cultures. By demonstrating respect for these preferences, healthcare providers can significantly enhance the patient's experience, making them feel valued and respected, which is crucial for positive healthcare outcomes. Next, establish ongoing professional development programs that reinforce the importance of cultural competence and communication accommodation. These programs should be regularly updated to reflect the latest best practices and emerging trends in international patient care. Continuous training ensures that healthcare providers remain proficient in adapting their communication styles and cultural sensitivity, thereby maintaining high standards of patient care and further promoting India as a leading destination for medical tourism.

By implementing these recommendations, Indian healthcare providers can significantly improve their communication with international patients, leading to enhanced patient experiences, greater satisfaction, and increased trust in the Indian healthcare system. This, in turn, will strengthen India's position as a preferred destination for medical tourism on the global stage.

IMPLICATIONS

This study highlights the critical role of effective doctor-patient communication in enhancing the experiences of international medical tourists in India, with a particular focus on the application of Communication Accommodation Theory (CAT). The findings underscore the importance of cultural sensitivity and adaptive communication strategies in fostering positive healthcare outcomes for patients from diverse cultural backgrounds. By adopting flexible communication styles that align with the cultural expectations and preferences of international patients, healthcare providers can build trust, improve patient satisfaction, and promote better adherence to medical advice.

The implementation of comprehensive cross-cultural training programs is essential for equipping Indian healthcare providers with the skills needed to navigate the complexities of doctor-patient communication in a globalized healthcare

environment. Emphasizing patient-centered communication, enhancing non-verbal communication skills, and incorporating cultural preferences into healthcare delivery are key strategies that can significantly improve the quality of care provided to international patients.

Also including technology advancements in training like augmented reality (AR) and virtual reality (VR) along with social media promotion of same will give it a larger audience and doctors a more efficient training medium.

Moreover, continuous professional development in cultural competence and communication accommodation will ensure that healthcare providers remain adept at meeting the evolving needs of the global patient population. By prioritizing these approaches, India can solidify its reputation as a leading destination for medical tourism, offering high-quality, culturally competent care that meets the expectations of patients from around the world.

In conclusion, the successful application of CAT in the Indian medical tourism industry has the potential to greatly enhance patient experiences, thereby attracting more international patients and contributing to the sustained growth and success of India's medical tourism sector. Through strategic investments in communication training and cultural competence, India can continue to build on its strengths as a premier destination for global healthcare.

LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

While this study provides valuable insights into the role of Communication Accommodation Theory (CAT) in enhancing doctor-patient communication within the Indian medical tourism industry, several limitations should be acknowledged. First, the study's reliance on self-reported data from patients may introduce biases as responses could be influenced by patients' perceptions, cultural backgrounds, or their experiences at the time of the survey. This may not fully capture the objective reality of communication effectiveness or patient satisfaction.

Second, the study was conducted within a single healthcare institution, which may limit the generalizability of the findings to other regions or types of healthcare facilities across India. The specific cultural and operational context of this institution may differ from others, potentially affecting the applicability of the results to the broader Indian medical tourism industry.

Third, the cross-sectional nature of the study only provides a snapshot of patient experiences at a single point in time. This approach does not account for changes in communication effectiveness or patient satisfaction over time, nor does it consider the long-term impact of communication strategies on patient outcomes.

Future research should address these limitations by incorporating longitudinal designs that track patient experiences over time to assess the durability of communication improvements and their long-term effects on patient satisfaction and health outcomes. Additionally, expanding the study to include multiple healthcare institutions across different regions in India would enhance the generalizability of the findings and provide a more comprehensive understanding of the communication challenges faced by international patients.

Moreover, future studies could explore the specific components of cross-cultural training that are most effective in improving communication accommodation and patient satisfaction, thereby providing targeted recommendations for healthcare providers in the medical tourism industry. Such research would further refine our understanding of how CAT can be applied to optimize patient experiences in diverse healthcare settings. It should also explore the balance between convergence and divergence strategies, particularly in cases where cultural beliefs might conflict with medical practices. Investigating how healthcare providers can maintain professional authority while still accommodating patient preferences could offer valuable guidance for improving doctor-patient communication in international medical tourism. Addressing these gaps will help refine CAT's application, ultimately contributing to more effective and culturally competent healthcare delivery in the global medical tourism industry.

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