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Physician-Patient Communication from an Intercultural Perspective: An Exploratory Study in the United Arab Emirates

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Abstract
The objective of the study is to explore physician-patient communication in an intercultural context —the United Arab Emirates — through the experiences of physicians. The United Arab Emirates is among the most diverse populations globally. Intercultural communication competence is highly valued in diverse environments, and it is particularly significant in professions such as health care. The study aims to assess the intercultural competence skills of physicians through their encounters. To explore this, semi-structured interviews with physicians living and working in the United Arab Emirates are carried out. The findings of the qualitative study conclude that language is seen as either an obstacle or a facilitator. The importance of nonverbal language, the role of interpreters, and Google Translate have been highlighted in overcoming the language barrier. Language is considered a barrier because it blocks the passing of emotions. Experience in the medical field has been mentioned as an advantage for overcoming communication barriers. Knowledge about the cultural background is one of the dimensions that guides physicians in how to communicate. Other dimensions are the personality of the patient, age, and education. The physicians mentioned that they are aware of the sensitive issues and can easily modify their communication. Trust plays a crucial role in physician-patient communication. Physicians generally perceive themselves as good communicators, a quality considered particularly important in the UAE. Key aspects emphasised include listening, providing follow-up, and being accessible, with language identified as one of the most essential communication skills.

Keywords
patient communication; physician communication; intercultural communication; culture; UAE.

Komunikasi Pakar Perubatan-Pesakit dari Perspektif Antara Budaya: Suatu Kajian Eksploratori di Emiriah Arab Bersatu

Abstrak

Objektif kajian ini bertujuan meneroka komunikasi antara pakar perubatan-pesakit dalam konteks antara budaya – Emiriah Arab Bersatu – menerusi pengalaman para pakar perubatan. Emiriah Arab Bersatu merupakan antara negara yang populasinya penuh kepelbagaian di seluruh dunia. Kompetensi komunikasi antara budaya sangat dihargai dalam persekitaran yang pelbagai, dan ini merupakan aspek yang sangat signifikan dalam pelbagai profesion seperti bidang penjagaan kesihatan. Kajian ini bertujuan menilai kemahiran kompetensi antara budaya para pakar perubatan melalui pertemuan mereka. Bagi meneliti kajian ini, temu bual separa berstruktur telah dijalankan bersama para pakar perubatan yang tinggal dan bekerja di Emiriah Arab Bersatu. Dapatan kajian kualitatif ini merumuskan bahawa bahasa dilihat sama ada sebagai suatu halangan atau pemudah cara. Kepentingan bahasa bukan lisan, peranan jurubahasa, dan penggunaan Google Translate telah diketengahkan dalam mengatasi halangan bahasa. Bahasa dianggap suatu halangan kerana ia menyekat penyampaian emosi. Pengalaman dalam bidang perubatan telah disebut sebagai suatu kelebihan bagi mengatasi halangan komunikasi. Pengetahuan tentang latar belakang budaya merupakan salah satu dimensi yang membimbing para pakar perubatan tentang cara berkomunikasi. Dimensi lain pula adalah seperti keperibadian pesakit, umur, dan pendidikan. Pakar-pakar perubatan menyebut bahawa mereka menyedari isu-isu sensitif dan mampu mengubah suai

komunikasi mereka dengan mudah. Kepercayaan memainkan peranan yang sangat penting dalam komunikasi antara pakar perubatan-pesakit. Pakar-pakar perubatan secara amnya menganggap diri mereka sebagai komunikator yang bagus, iaitu satu kualiti yang dianggap sangat penting di Emiriah Arab Bersatu (UAE). Aspek utama yang ditekankan termasuklah mendengar, menyediakan rawatan susulan, dan boleh dihubungi, dengan bahasa yang dikenal pasti sebagai salah satu kemahiran berkomunikasi yang paling penting.

Kata kunci

Komunikasi pesakit; komunikasi pakar perubatan; komunikasi antara budaya; budaya; UAE

Introduction

Effective communication is an important facilitator for achieving the goal of communication, and especially in the healthcare sector, this is of vital importance. A good communication establishment between the patient and the physician is an important step for an accurate diagnosis and the treatment of the patient. If there is a communication barrier between two parties, ineffective communication may result in serious consequences. As stated by Schouten et al. (2005), the communication barrier between patients and physicians can give rise to different types of health-related problems and can affect the quality-of-care patients receive. Competent physician communication results in improved health outcomes and increased patient-physician satisfaction (Paternotte et al. 2016). However, linguistic and cultural barriers between physicians and patients can easily create communication gaps and challenges for effective communication affecting the quality of healthcare (Schouten et al., 2005; Paternotte et al., 2017).

However, not much is known about the issues in communication between healthcare individuals and patients from different cultures (van Wieringen et al., 2002). There have not been many studies done on the characteristics of intercultural communication in the healthcare industry (Gibson & Zhong, 2005). Patients' cultural background is important in patient-physician interaction but not paid much attention as it deserves (Schouten et al., 2005). Patient-centred communication between healthcare providers and receivers is necessary for high-quality patient care (Paternotte et al., 2016). This study focuses on physicians' communications with their patients the United Arab Emirates (UAE). The UAE's population including nationals and expatriates are 9,282,410 in 2020 according to Federal Competitiveness and Statistics Centre. The largest community in the UAE is Indians, followed by Pakistanis, Bangladeshis, Asians, Europeans, and Africans.

The model underpinning the study is Deardorff's (2006) Process Model of Intercultural Competence. The model is process-oriented: intercultural competence is seen as a lifelong and continuously improvable process (Hagar, 2018).

Intercultural communication competence is vital in diverse healthcare settings. This study explores physicians' intercultural competence through their clinical encounters using semi-structured interviews with physicians practicing in the UAE. The interview questions were informed by the MAAS Global Observation Scale, a validated instrument for assessing patient-centred communication (Patternotte et al., 2016). Although originally developed as an observational tool, the scale was adapted to guide the interview questions in this study. Deardorff's Process Model of Intercultural Competence was used to interpret and relate the study findings.

In highly diverse contexts such as the UAE, there should be more studies that explore physician–patient communication from the physicians' own perspectives. Less attention has been paid to **physicians' own perspectives and lived experiences** of intercultural communication during routine clinical encounters. Addressing this gap, the present qualitative study examines intercultural physician-patient communication through semi-structured interviews with physicians practicing in one of the most culturally diverse populations globally, offering contextually grounded insights into how intercultural competence skills are perceived, enacted in clinical encounters. Moreover, while highly multicultural contexts are often cited as ideal settings for studying intercultural healthcare communication, there remains a **limited body of qualitative research examining how physicians navigate cultural diversity in everyday practice.**

The findings contribute to the literature by offering an **experience-based understanding of intercultural communication in healthcare,** complementing existing studies. Furthermore, the study extends intercultural competence research by grounding physician experiences within a theoretical framework of intercultural communication competence, thereby informing future research, and training.

Literature Review

Intercultural Communication in Health Context

Studies state that intercultural communication barriers stem to a great extent from language barriers and differences in cultural values concerning health and communication (Schouten et al., 2005). Moreover, the quality of patient-physician communication may also be affected if the physicians feel incompetent to communicate with patients from different cultures and backgrounds (Paternotte et al., 2015). Research shows that variations on cultural values such as individualism-collectivism, high context-low context, and other diverging cultural values do impact the individuals' communication behaviour (Schouten et al., 2005). A study that looked at the factors influencing physician-patient communication listed these challenges as language, cultural and social differences, and doctor assumptions (Paternotte et al., 2015).

A study conducted in the UAE by the *National*'s YouGov survey found out that UAE residents prefer physicians of the same nationality. Most of them feel that it is easier to communicate with a physician when he/she is from their nationality. Communication effectiveness is particularly important in interactions between the healthcare provider and the patient (Gibson & Zhong, 2005). Therefore, developing and improving competence in medical communication skills —a complex process— is something that all healthcare professionals should be concerned with throughout their medical careers (von Fragstein et al., 2008).

Chen and Starosta (2008) state that people from different cultures should learn to look with their eyes, hearts, and minds to people who are not from other cultures. Schouten et al. (2005) emphasize that due to the increasing cultural diversity in many Western countries, the cultural and ethnic background of patients have become increasingly important as factors affecting physician-patient communication. It is obvious that communication diversity between cultures can easily create communication problems and misunderstandings between members of different cultures (Schouten et al., 2005). Intercultural communication, as a field, offers a useful perspective that can raise awareness of common pitfalls that can often cause miscommunication (Hallenbeck, 2013). Recognising the communication limitations and developing skills on how to overcome barriers in the joint decision-making process of the physician and the patient can improve this process in an intercultural context (Suurmond & Seeleman, 2006).

Hajek and Giles (2003) define intercultural communication competence as "the process of obtaining desirable communicative outcomes through the appropriate management of levels of individuation/stereotype expectation in communication, given a cognitive awareness of all participants' cultural orientations, cultural history, and motivations." In the 21st century, humanity is living in a multicultural environment more than ever and this implies that many health practitioners must interact with people from different cultures.

Communication problems in intercultural encounters can lead to misdiagnosis, as good communication is vital to effective healthcare (Watson, 2008). If the patient has a sociocultural background that the healthcare provider is not familiar with, this situation may cause a feeling of dependency and dissatisfaction on the part of the patient. At the same time, it may cause frustration and misunderstandings on the part of the physician (Betancourt et al., 2000).

When physicians and patients communicate in the same language and have similar cultures, patients better understand the information given by the physician and participate more actively in the interaction (Seijo et al., 1991). At the same time, it has been found that the intercultural anxiety levels of healthcare providers are

associated with effective intercultural communication (Ulrey & Amason, 2009). Ineffective intercultural communication can lead to stress and job dissatisfaction for healthcare providers (Gibson & Zhong, 2005).

In intercultural communication, language and culture can negatively affect the success of interaction. When this occurs in professional settings such as healthcare, it can cause misunderstandings and communication problems that can have serious consequences on health outcomes and patient safety (Hamilton & Woodward-Kron, 2010). The first and most obvious challenge in cross-cultural encounters is the language barrier between healthcare providers and patients (Betancourt et al., 2000). In their research, Shapiro and Saltzer (1981) found the following: "The interaction of factors of language, translator and ethnicity appeared to have a highly significant influence on whether the medication prescriptions were understood by the patient." Rivadeneyra et al. (2000) concluded that Spanish-speaking patients are at a double disadvantage when confronted with English-speaking doctors. In their study, it is stated that Spanish-speaking patients made fewer comments, and their comments were more likely to be ignored. It is concluded that communication difficulties can lead to low compliance rates and worse medical outcomes among Spanish speaking patients.

Both migrant patients and physicians need intercultural communication skills so that they can both receive and provide satisfactory health care. The physicians are faced with a diverse group of patients, and their clinical encounters are full of cultural signs and meanings (Rosenberg et al., 2006). Meeuwesen et al. (2006) found that consultations with non-Western immigrant patients were shorter than two minutes and the power distance between physicians and these patients was greater when compared to Dutch patients. It has been reported that efforts to make significant improvements in medical trainees' communication skills will require significant changes in teaching at both undergraduate and graduate levels (King & Hoppe, 2013)

Multicultural healthcare settings require excellent communication to foster trust and, understanding between patients and physicians, where language difficulty, communication styles, and cultural expectations can hamper patient participation and satisfaction. According to a systematic review, most studies have concentrated on patient perceptions, not physicians' experiences. These findings highlight the necessity for systematic intercultural communication training in different multicultural healthcare settings that includes language use, gender sensitivity, and ethics (Zhao, 2023).

Deardorff's Process Model of Intercultural Competence

Deardorff's (2006) Process Model of Intercultural Competence was developed through a Delphi study that involved intercultural scholars and higher education administrators regarding the core components of intercultural competence. It proposes that intercultural competence emerges through the continuous

interaction of attitudes, knowledge and skills. These three foundational components together produce internal and external outcomes. This framework is used in this research for the healthcare context.

According to the model, foundational attitudes such as respect, openness and the suspension of evaluative bias support the acquisition of cultural knowledge and adaptive communication skills. These components operate cyclically, generating internal capacities such as empathy, flexibility, and ethnorelative perspectives, which subsequently strengthen communication and behaviour perceived by others as appropriate (Deardorff, 2006; Deardorff, 2009). The **external outcome** is the ability to **communicate and behave effectively and appropriately in intercultural situations**. Effectiveness relates to goal achievement, and appropriateness is evaluated by others according to cultural norms. Intercultural competence is strongest when **internal and external outcomes mutually reinforce one another** (Deardorff, 2006; Spitzberg, 1989)

MAAS-Global ICC Observation Scale

The MAAS-Global Observation Scale has been used to assess doctor–patient communication skills. Originally, it was developed as an observational tool. The MAAS-Global evaluates communicative behaviours across key phases of the medical consultation, including both relational and instrumental aspects. These are:

These include:

1. **Introduction and agenda setting**, which assesses how the physician initiates the consultation and clarifies the patient's reason for encounter,
2. **Exploration of the patient's perspective**, focusing on eliciting concerns, expectations and emotions,
3. **Information gathering and structuring**, evaluating clarity, coherence and responsiveness during history-taking,
4. **Explanation and shared decision-making**, assessing how diagnoses, management plans and advice are communicated
5. **Closure of the consultation**, including summarising information and checking patient understanding (van Thiel et al., 2000)

It is a well-established and validated instrument for examining physician communication behaviours. Empirical research has demonstrated the validity and applicability of the MAAS-Global in clinical settings. For example, van Es et al. (2012) applied the MAAS-Global to assess general practice trainees' consultation skills and identified a two-dimensional structure of the scale, distinguishing between patient-oriented and task-oriented communication behaviours. components of effective clinical communication.

The scale has also been employed in assessment and training contexts. In a study examining communication

skills assessment within Objective Structured Clinical Examinations, Setyonugroho et al. (2018) used the MAAS-Global as a standardisation instrument to compare communication performance across examination settings. This study further highlights the utility of the MAAS-Global as a benchmark for assessing patient-centred communication skills in diverse educational and clinical contexts.

Method

Recent studies are more patient-focused emphasising the importance of patient to physician communication (Gibson & Zhong, 2005). This research reflects the physician focused perspective. The instrument that guided the questions of the study for the interviews was taken from MAAS Global Observation Scale. It is a validated instrument for assessing patient-centred communication (Patternotte et al., 2016). This is an observation scale, but it has been adapted to guide the questions. This instrument has been combined with the factors influencing intercultural communication competence (ICC) from the study of Schirmer et al., 2005. There are several models of intercultural competence that lists skills, abilities and attitudes. However, this research can be the start of an initiative for developing an integrative model for the healthcare in the UAE.

"Qualitative interviews-semi-structured or unstructured, with individuals or with groups – continue to predominate in the social and cultural geography subdisciplines." (Dowling et al., 2016). Qualitative interviewing is a "flexible and powerful tool to capture the voices and the ways people make meaning of their experiences" (Rabionet, 2011). As stated by Donalek (2005), conducting qualitative research is a fulfilling experience where in a successful interview, on a deeper level, connections are made. In the interview, stories are shared, and this is an important "gift" for the researcher. The interview guide should be prepared carefully, and the researcher needs to take into consideration the main question of the study where the information in depth will be gathered (Kallio et al., 2016).

The semi-structured interviews are conducted from 4th of July until the 19th of July 2021. All the physicians live in the UAE. The interviews lasted around 20 to 55 minutes and conducted in English. Table 1 shows the sample characteristics, and the interview mode. A total of 10 physicians were interviewed. The interviews were recorded with the consent of the participants and transcribed verbatim. Informed consent from the participants of the study was taken.

The youngest of the physicians was 26 and the oldest was 57 years old. There were only two female participants, and only one participant did not speak Arabic. They were mainly from the Emirate Sharjah, and

Dubai.

In **qualitative research,** the goal is **depth and contextual understanding.** Our sample consisted mostly of **Arab-speaking and predominantly male** participants. However, we studied physicians' communication in a country where Arabic is the dominant language, and the medical workforce (doctors) is male-dominated. The sample represents the sociocultural and professional reality of the context. The participants in the study are recruited through snowball sampling.

Table 1 Physician Sample

Nationality	Years of living in the UAE	Specialty	Interview Mode
Egypt	21 years	Internal medicine	Zoom
British and Pakistani	7 months	Gastroenterology and internal medicine	MS Teams
Syrian	8 years	Internal medicine Cardiology	Botim
Egypt	45 years	Radiology	MS Teams
Jordan	7 years	Ophthalmologist	Zoom
Egypt	10 years	Ophthalmologist	MS Teams
Egypt	4 years	Dentist	MS Teams
Egypt	20 years	Surgeon	MS Teams
Iraqi	15 years	Dentist	Zoom
Pakistani	19 years	Gynaecologist/obstetrician	Zoom

The research questions are as follows:

RQ1. What are the communication barriers with the patients across different cultures?

RQ2. What are the facilitators of communication between the physicians and the patients?

RQ3. How to improve patient-physician communication?

Most of the physicians had their training in their home countries except for two physicians, who studied in United Kingdom. Two of the interviewees completed their studies in the UAE. Most of the physicians stated that they did not have any specific training on communication skills in their medical studies. Very few did courses in their studies (electives) on communication and later attended communication certificate programs (specific to the medical field) voluntarily in the UAE.

The data were analysed thematically, and not all data generated from the interviews are reported in this manuscript. Braun and Clarke's (2006) six-phase reflexive framework was followed, including familiarisation with the transcripts, generation of initial codes, searching for and reviewing themes, and defining and naming final themes through an iterative process.

Findings

The themes reported emerged from the thematic analysis of the interview data.

Communication with the Patients/Accompanying People

It had been reported that the communication with the patient start by asking the patient about his/her issue. The people accompanying the patient are included in the conversation always if the patient is elderly or if he/she is a child who is accompanied by their parents. Confidentiality of the patient information is mentioned in the interviews.

In the interviews, the relationship of the person accompanying the patient is considered important. One physician mentioned that he is not asking about the relation of the accompanier to the patient if the patient answers the questions. In the words of one physician, "If he is coming with one of the family members, first degree like father, mother, no harm, for him to expose his confidential data… but coming with a friend, sometimes I prefer the friend to go outside." (Participant 6).

The physicians, in communicating with the patients mentioned similar actions. "All the doctors, we were trained to get information from the facial expressions..." (Participant 4). Another factor how the physicians communicate with the patient is related to whether the patient is a first-time patient or a second-time visit. If the physician is seeing the patient more than one time, then "social communication" takes place.

It has also been underlined that the specialty of the physician makes a difference in how they start the conversation. It is highlighted that the physicians need to double-check the information the patient gives them. In the words of one physician: "I usually explain to my medical students that in our specialty, we do not depend a lot on patients' words…It is important how the patient explains his problem to you because this can guide you to focus your examination." (Participant 5). It was reported that the culture, the patient, and the education, all have a role, and the physicians ask further questions if they think there is a confusion. The non-Arabic speaking physician underlined that he checks whether the patient is the "right" patient. He also added that all the people in the room, students and/or a nurse, have been introduced to the patient. "…So everyone knows everyone." (Participant 2).

Education of the patient has been reported as making a difference not only in terms of establishing the

communication style, but also in terms of the instructions given about the treatment. For example, if the patient has higher education, then the physicians explain it more in "medical terms." In the words of a physician:

> Explaining something in English is different than explaining something in Arabic. Old people who are not reading or not using the computer, instructions will be different. Some people who can open the computer easily I can give him site, website…Usually, it will differ according to a lot of things, one of them is the nationality, age, education, the IQ, all these differ. (Participant 1).

Language is seen as either an obstacle or a facilitator between the two parties, depending on what is the native language of the patient and the physician. The non-Arabic speaking physician mentioned that he is double-checking whether the patient has understood him or not, and if English is not the first language of the patient, then he is getting the aid of his nurses and students. He also added the use of drawing pictures and diagrams to illustrate what he means, including gestures as well. An Arabic-speaking doctor mentioned "with Arabic people, no problem, this is my mother tongue… they can know from my face, from my reactions, they know I am understanding. It is different for other nationalities..." (Participant 1).

Awareness of the Cultural background of the Patient

Within the intercultural communication context, the age, education, gender, and personality of the patient have also been discussed. Most of the physicians, although they indicated that they pay attention to the cultural background, underlined that another equally important indicator of how they would adopt their communication skills is the education level of the patient. "…how she perceives the answers from me rather than where she belongs, from USA, UAE or Jordan…" (Participant 10).

The physicians have not talked about generalisations of the cultures but rather highlighted their role as healthcare provider helping their patients. Even so, participants sometimes leaned on general cultural, national, or gender stereotypes when sharing their experiences. They pointed out some fairly noticeable differences in how people prefer to communicate and how comfortable they feel during clinical visits. For instance, some participants mentioned that certain patients seem to relax more when talking to a female healthcare provider, while others tend to hold back during sensitive conversations, especially at the start of the doctor-patient relationship. Over time, though, trust often grows, allowing patients to open up more once they see their physician as someone they can really trust. Interestingly, many mentioned using digital tools like social media to stay in touch with some patients outside of regular appointments. A number of participants shared that some patients liked having their spouses involved in discussions about their care and wanted medical updates shared

with them. While these preferences sometimes tied back to broader cultural or social norms about family roles, it was clear that this was usually something the patients requested themselves. It showed their comfort with making decisions together rather than a sign of them lacking autonomy. It is worth noting that views on who accompanies patients during medical visits can really differ based on culture and nationality. Some individuals come solo, while others bring family members along for support. However, participants stressed that these preferences are unique to each person and should not be seen as one-size-fits-all. Additionally, participants reflected on the importance of being sensitive to gender and cultural nuances in how they communicate. A few mentioned that conversations around reproductive health need extra care regarding social norms, like marital status to ensure everything stays respectful and appropriate. They also talked about how expressions of resilience or hope, even reliance on faith, can pop-up in-patient stories. These insights felt more like individual experiences shaped by personal beliefs rather than traits tied to any specific cultural or gender group.

The physicians considered experience as a key factor to overcome cultural misunderstandings: In the words of one participant: " I can understand from closeness, from the age, from the accessories they are wearing, from the sound they are making from the throat, I mean, I can understand nationality like that…I know because I am in Dubai long time, and I met all the nationalities..." (Participant 1).

Participants noted that religious beliefs can influence how patients communicate and how discussions are approached, depending on individual beliefs. They also indicated that awareness of gender- and culture-related factors may be clinically relevant in some situations, particularly where certain health conditions are more common in specific populations, while emphasizing that such factors are considered alongside individual assessment.

One of the interviewees summarised how he deals with patients from different cultural backgrounds in this way: "...Remember, what you do not want to do is judge a book by its cover, so you still have to ask all the relevant question…I am sorry I do not want to offend you, but I have to ask this question. I kind of tone it down a little bit and they do not feel uncomfortable answering the question. (Participant 2).

Physical Examination and Treatment

The participants were already aware of the sensitivity of the physical examination of their female patients. It was reported that some female patients are shy, and they do not want to see male physicians. Physicians implied that this is their job and examining a patient is very normal although there are things that they need to pay attention. The examination of a male patient is explained in this way. "…You will do the same, but

sometimes the patient is in a hurry, nurses are out, and you can examine a male patient without a nurse." (Participant 8). Physicians mentioned the mandatory procedure that there must be a nurse during the examination and without the approval of the patients, one cannot take photos.

Regarding treatment, participants reported that all patients are given the same information, regardless of their background. Participants explained that patients are presented with all available treatment options, and in some cases, patients may already have substantial knowledge about their condition. One physician described encouraging patient involvement by supporting shared decision-making and recognising patients' expertise in their own care. This approach was contrasted with clinical practices in the physician's country of training, where patients are less commonly involved in treatment decisions.

Self-evaluation in terms of Communication Skills and Intercultural Competence

Most of the physicians stated that it is not up to them to judge themselves on this, and their patients and nurses can comment better than they. In general, the physicians evaluated themselves as doing well and mentioned two important points on what they do well. One is "experience" and the other one is being aware of "communication" in their profession. Some physicians completed their medical studies in the past and communication specific training were not offered in their medical curricula at that time. However, they do appreciate its importance in the curriculum, but add that the personality of the physician can make a difference in this respect as well. It was mentioned that in the UAE, the physicians are being exposed to different cultures. Being exposed to different backgrounds is helping them to improve their communication skills because this is a "natural communication and intercultural communication development site."

Important Communication Skills and Communication Barriers

"The follow-up with the patients" is indicated as an important communication skill. Listening has come up as an important dimension in the interviews. "…but with listening, you will be a better doctor, and added that most doctors do not have time…"(Participant 8). The communication skills mentioned by the physicians are empathy, respect, misjudgement, and eye contact. Whatever the culture is, the barrier can be removed by a big smile and helps the patient relax. "Does not need any training. Needs experience. Break the barrier." (Participant 6).

By far, language was mentioned as an important communication skill. The physicians explained their attempts to communicate when faced with a language obstacle. They said that they call the nurse who speaks the language or call the husband of the patient or uses illustrations/diagrams to explain.

They also considered being accessible to their patients as an important communication skill. Language was

seen as a very important barrier. One interviewee mentioned how "google translator" helps. Even though interpreters are used, the physicians do not feel comfortable with this. In the words of one participant:

> "…the biggest issue is the language barrier, and I would love to be able to speak Arabic so that I can communicate directly with my patients rather than an interpreter because no matter how good the interpreter is, it never gets translated the way the patient wants…Sometimes one Chinese patient is coming, they do not know anything in Arabic or English. So, all our interview is around the mobile. He is writing something in the Google translator, and I am writing the same thing in the Google Translate. This is difficult." (Participant 2).

Participants noted that patients often arrive with multiple concerns, making it important for physicians to understand their emotions and perspectives. However, this can be challenging when language barriers are present.

Conclusion

The findings of the research have been classified based on MAAS-Global ICC Observation Scale dimensions. Table 2 is a summary of the research findings.

Table 2 Study Results based on MAAS-Global ICC Observation Scale

	The Study Results
Opening	According to the language ability of the patient, the physician changes the behaviour (calls the interpreter, nurse) The characteristics of the patient result in the physician dealing with the relatives, friends of the patients Listens Reacts to possible cultural differences (Checks nonverbal language signs such as clothes, accessories)
Reason for Encounter	Demonstrates being alert to cultural aspects for "medical reasons" as well (eg some illnesses are more prominent in some cultures and females or males than others) Checks reasons of encounter of the relatives
Physical Examination	Demonstrates sensitivity to different cultures (does not ask the female patient to take off the clothes immediately, feels what he, she has to do with the patient

Diagnosis	Explains cause and relation of the complaint within the expectations of the patient (age and education matters on how this is communicated/explained)
	Checks if the patient understood the explanation (especially when there is language barrier, use of diagrams, illustrations, body language, and double checking)
	Checks if the relatives understood the explanation depending on the situation (elderly patients and minors)
Policy	Adapt cultural differences in diagnosis and policy (offers substitute medication)
	Explains referral to other healthcare workers (eg to female physicians)
Explore	Explores the reason for consultation, wishes and expectations
	Recognizes misunderstandings caused by a language barrier
	Responds to non-verbal behaviour and keywords
	Responds to cues/key words which are related to cultural differences
Emotions	(Empathy-sympathy concepts not clearly understood by the physicians)
	Believe in empathy and thinks it is important skill for the physicians.
	Listens actively
	Reflects on the feelings of the patient
	Tries to empathise the patient's emotions
Information	Checks the foreknowledge of the patient about diagnosis or expected policy
Transfer	Gives information in small amounts (based on education, age)
	Gives concrete explanations (further explain, more explanations when necessary)
	Uses concrete language (chooses which terms to use depending on the patient's knowledge, and use medical terms or not)
	Asks if the patient understood the information (happens more when there is a language barrier) Uses different ways to explain (when there is language barrier)
Summarizes	
Structure	Applies an adequate time schedule
	Takes the time (even though there are other patients waiting outside with appointment)
	Follow-up (WhatsApp, and other means)
Empathy	Shows concern, is inviting and sincere, commiserates by means of eye contact and non-verbal behaviour, shows compassion for the patient (Smile, strong)
	Commiserates with verbal reactions
	Observes cultural differences (strongly so that they do not make a mistake)
	Shows empathic behaviour
	Has an open attitude (it depends: if the patient is known with time and if he/she is from the same culture and nationality)
	Shows respect for the patient (strong)

Consult	Has a *prejudiced* attitude
Evaluation	Shows awareness of his or her own cultural and professional context
	Shows awareness of cultural differences
	Speaks more languages
	Shows to have learned from previous consultations with ethnic minority patients (mainly experience, not formal training)

Source. Paternotte et al., 2016. Adapted from MAAS-Global 2000 Manual and Factors Influencing ICC.

Using the MAAS-Global ICC Observation Scale as a guide, the results showed that physicians' ways of communicating outline with several key areas of the scale, especially when it comes to gathering information, transferring it, showing empathy, and having a clear structure. However, it also showed that intercultural skills often come more from real-life experience than formal training.

When it comes to adapting communication and gathering information, the findings showed that physicians modified their strategies based on things such as patients' language skills, age, education level, and even whether family members were around. Language was definitely a major factor: it really influenced how well doctors could grasp what their patients were feeling and what they expected. When both parties shared a language, conversations often went beyond just medical matters to social and emotional aspects too, and this really helped build trust. However, when there were language barriers, doctors had to get creative with non-verbal cues, visual aids, interpreters, or help from nurses and family. These observations support what the MAAS-Global highlights about actively checking for understanding and being responsive to both verbal and non-verbal signals. Still, interpreters sometimes did not quite get the emotional subtleties of what patients were expressing. This underlines how crucial language skills are not just for getting the facts right but also for connecting with patients on a deeper emotional level during appointments.

As for cultural awareness impacting clinical settings, the results showed that physicians' understanding of their patients' cultural backgrounds, including gender and religious contexts, shaped how they communicated and made clinical decisions. They considered things like common health issues in certain demographics when diagnosing symptoms and suggesting treatments. However, these considerations did not overshadow individual assessments; they seemed to aim for a balance between being culturally aware and exercising their professional judgment. Some physicians admitted they sometimes leaned on generalisations based on culture or nationality. While they tended to approach these thoughts cautiously, it still highlighted the fine distinction between drawing on personal experience and risking oversimplification. Real-world exposure often builds intercultural competence more than formal training does.

Empathy was another big theme in all the interviews, tying closely into those MAAS-Global Emotions and Empathy components. Physicians talked about how crucial it was to listen closely, pick up on emotional cues,

and reflect back what their patients were feeling. Some even mentioned feeling a bit unclear about where empathy ends and sympathy begins. They recognised that non-verbal signals like eye contact and body language are key in establishing trust especially across cultures. However, language barriers popped up as a significant challenge for truly understanding emotions. Even though physicians tried hard to connect through gestures and by being attentive listeners, they admitted it was tougher to fully understand patients' feelings when verbal exchanges were limited. This really reinforces that empathic communication is not just about sharing information but is deeply intertwined with effective conversations, especially in intercultural scenarios.

When talking about shared decision-making and information transfer, physicians expressed their commitment to making sure all patients received detailed info about their diagnoses and treatment options, no matter what the background is. They tailored explanations based on education levels or prior knowledge while checking in frequently to ensure understanding. A few physicians noted that nowadays patients seem more informed and eager to take part in decisions about their care, which aligns with patient-centered care ideals in the MAAS-Global framework. One physician compared this collaborative approach with practices from their home country where patient involvement in decision-making is less common. This illustrates that different institutional and cultural settings shape communication styles, showing how the UAE healthcare system fosters shared decision-making alongside professional accountability.

When asked about developing intercultural communication skills, physicians pointed out that experience was key. Being exposed to various patient backgrounds felt like a "natural learning environment" that boosted their adaptability and confidence. While they recognised the value of formal communication training, many felt it was not something they had seen much in earlier medical schooling and that their intercultural skills largely came from hands-on experiences.

Besides the MAAS-Global framework, we looked at the findings through Deardorff's Process Model of Intercultural Competence from 2006. This model explains intercultural competence as a dynamic and evolving journey that includes attitudes, knowledge, skills, and both internal and external outcomes. It focuses more on adaptability and the process itself instead of just sticking to fixed cultural traits. This resonates with what physicians shared about their learning experiences and how they adapt to various communication situations. During the interviews, the participants showed foundational attitudes like respect, openness, and curiosity. They talked about things like not being judgmental, keeping patient confidentiality in mind, and tailoring their communication to fit each patient's unique needs rather than making assumptions based on culture. They stressed the importance of asking clarifying questions, being careful with sensitive topics, and making sure patients felt comfortable. Language played a huge role in their interactions. Physicians mentioned using non-

verbal cues, visual aids, repeating important points, and working alongside nurses or interpreters to bridge communication gaps. A key takeaway was that intercultural competence really seems to develop through lots of exposure to diverse patient groups rather than just formal training and this aligns with Deardorff's idea of competence being iterative. The interviews also uncovered some strong internal outcomes like empathy, flexibility, and perspective-taking, where doctors highlighted emotional awareness, active listening, and building trust during repeated encounters. On the external side of things, they managed to communicate effectively by giving tailored explanations, involving patients in decision-making, being sensitive during examinations, and including families in discussions.

Physicians have confidence in the UAE healthcare system and are aware that professional standards are closely monitored. As a result, they approach their interactions and communication with patients thoughtfully and carefully.

Limitations

The study has several limitations, including a small sample within a single healthcare context, Linguistic diversity, as most participants shared similar linguistic and cultural backgrounds. The limited inclusion of non-Arabic-speaking physicians may restrict insight into communication challenges. Also, the female physicians' experiences are underrepresented.

In addition, the study relied solely on **physicians' self-reported accounts;** thus, the findings may reflect participants' perceptions of their communication practices rather than direct observation of their communication with patients or reported experiences of patients.

MAAS-Global is used as an interpretive rather than observational tool in the research. Although Deardorff's Process Model of Intercultural Competence informed the interpretation of the findings, the study did not directly examine changes in attitudes, internal outcomes, processes over time. Conclusions regarding the development of intercultural competence are interpretive rather than longitudinal.

Future research could explore larger and more diverse samples of physicians, examine the development of intercultural communication skills with time, and assess the impact of targeted training programs on communication effectiveness. Including patient perspectives would also provide a more comprehensive understanding of communication dynamics in multicultural healthcare settings, such as those in the UAE.

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During the preparation of this work, the authors used AI tools in order to proofread the paper. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.