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RESEARCH ARTICLE

# MEDICAL TOURISM: CULTURAL BELIEFS, EXPECTATIONS OF PATIENTS AND QUALITY OF EXPERIENCE IN A DESTINATION HOSPITAL

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## ABSTRACT

**BACKGROUND:**

Medical tourism (MT) involves international travel to receive medical care and India has become a leading MT destination on account of affordability (60-80 percent cheaper than the developed nations), accreditation by Joint Commission International and National Accreditation Board for Hospitals, highly skilled doctors, advanced healthcare facilities and short waiting times. Research has consistently shown that poor cultural awareness results in MT patient misunderstandings, poor quality of clinical experience, and non-adherence to post operative medical advice. Grounded in the Communication Accommodation Theory, this empirical study examines the role of cultural beliefs and expectations of international patients' regarding their intercultural experience in a host country hospital in India immediately after their initial in-person meeting with the team of attending doctors.

**METHODS:**

This self-reported, questionnaire based, cross-sectional study was conducted at a NABH (National Accreditation Board for Hospitals & Healthcare Providers) and JCI (Joint Commission International) accredited, and Government of India designated healthcare institution for MT in New Delhi. A convenient sampling technique was utilized to select a sample originally comprising 1,600 medical tourism patients. Data were analysed using multiple linear regression tests and Smart PLS for mediation-moderation and Confirmatory Factor Analysis.

**RESULTS:**

The results show that international patients develop certain beliefs about cultural sensitivity practiced in a destination hospital from various information sources. These beliefs create culture and communication expectations about responsive MT services, which, in turn, influences the perceived quality of their experience regarding communication accommodation in the clinical encounter.

**CONCLUSION:**

Expectation management and confidence building of MT patients are the two critical activities that designated MT hospitals could adopt. Apart from designing and developing training programmes in intercultural communication (ICC), hospitals can develop belief in India's capability as a reliable medical tourist hub by investing in MT websites. Information regarding Indian culture and tourism potential along with inclusion of simulations based on augmented reality (AR) and Virtual reality (VR) could be uploaded to show how Indian doctors convergently accommodate with patients belonging to different nationalities.

**KEYWORDS**
medical tourism, culture, communication, patient belief and expectations, patient experience

## INTRODUCTION

Medical tourism (MT) has emerged as a booming industry, with millions of MT patients traveling internationally each year for various medical treatments. India has become a leading MT destination on account of affordability (60-80 percent cheaper than the developed nations), accreditation by Joint Commission International and National Accreditation Board for Hospitals, highly skilled doctors, advanced healthcare facilities and short waiting times. [1]. The country received 6,44,387 medical tourists in 2024 (https://www.pib.gov.in/PressReleasePage.aspx?PRID=2153611). Key themes in the systematic literature review on medical tourism [2] include the importance of quality care, cost savings, as also the role of cultural competence in MT patient satisfaction [3]. Research also points to India's diverse cultural landscape as both a strength, and a challenge, in providing culturally sensitive care [4]. The provision of e-medical visas and presence of medical tourism boards, along with the Heal in India initiative of the government of India have added fillip to the growth of MT in India. Competition from Thailand, Singapore, the USA, and Mexico is increasing lately; Singapore is now actively promoting its culture and accommodation practices to attract MT patients [5]. This indicates taking a holistic view of the MT practices in India to boost medical tourism and market its strengths

Research has consistently shown that poor cultural awareness on the part of the host country hospitals result in MT patient misunderstandings, poor quality of clinical experience, and non-adherence to post operative medical advice [6,7] underscoring the need for a planned cultural communication strategy [8]. Recent studies have shown that in comparison to the doctor-patient interaction belonging to the same country, the MT patient-doctor interaction belonging to different countries have shown higher instances of disillusionment, poor quality of clinical experience, and even opt-outs [8]. Intercultural communication (ICC) in medical tourism, has been described as a 'potential source of low-quality communication' [9], with poor healthcare outcomes. Leave aside culture, even communication competency has been found to be sorely lacking in doctors leaving the MT patients dissatisfied and disgruntled with the MT services [7, 11, 12, 13].

Differences exist between the cultures of western and non-western regions especially relating to cultural beliefs, communication styles, and expectations. For instance, the western cultures are explicit, individualistic, and direct in their communication styles. In contrast, the non-western cultures are much more implicit, relationship oriented and indirect in their communication [9,10]. In western countries, a direct and blunt approach is appreciated along with adherence to prescribed set of rules; in non-western countries directness is perceived as rude, decision making is deemed to be collective, and rules may be overturned for convenience. Another difference pertains to greeting styles and physical contact between genders belonging to eastern and western cultures; even between conservative Muslim countries and non-conservative Muslim African countries [14].

MT patients differ in their cultural belief systems regarding the type of healthcare services they would like to receive from the host country hospital [15] and this has the potential to influence outcomes [16,17, 18]. For example, some cultures prioritize holistic and traditional approaches to healing, while others may place more trust in modern, evidence-based medicine. Gender-based clinical examination practices also vary widely across cultures [15].

Globally, medical tourism is a well-researched area, with studies exploring various dimensions such as MT patient motivations, economic impact, MT facilities, and healthcare quality [19]. Much of the healthcare research in medical tourism is related to service delivery, choice of host country, or effect of language differences, and very few on MT patients' experience in the host country hospital [20]. There is a gap in the understanding of how medical tourists communicatively engage with physicians belonging to a different culture [21]. Moreover, there is less understanding of how MT patients' ICC beliefs on healthcare in a host country hospital influences patients' expectations and experiences.

The two prominent indices measuring MT patient satisfaction: The Medical Tourism Index [22], and the Medical Tourism Experience Scale [23], lack items related to culture and communication. While the former does measure 'cultural and religion match', emphasis is on similarity rather than on differences. Similarly, the Medical Tourism Experience Scale measures the experience in the destination culture, labelling it as 'arts and other manifestations of human intellectual achievements available in the destination', and not on the perceived quality of intercultural communication (ICC) experience in the destination hospital.

Defined as the "subjective mental state felt by the participants" [24], the clinical experience of tourists influences behavioural, affective and cognitive feelings towards a destination. Experience affects satisfaction, loyalty and the sense of well-being as also consumption-related emotions [24]. While there does exist a 'memorable tourism experience scale' based on destination attributes, it excludes the measurement of tourists ICC experiences [27]

Apart from clinical experience, managing medical tourist expectations in service delivery is critical for patient experience, satisfaction and loyalty [25]. Expectation management or EM in healthcare context is a communicative process whereby each party is clearly told in advance what to expect, when, by whom, where and how. Healthcare expectations have been found to be related to subjective factors such as the communication and the cultural competence of the doctors, apart from the objective factors such as cost, treatment duration, prescribed medicines and medical tests [25]. In truth, patients are themselves unaware of their expectations, consumed as they are with the treatment and other concerns. They may have a mental picture about their expectations, but it is rarely sought to be verbalised in most medical settings. The listing of these expectations, researchers agree, is a highly documented activity. Unmet expectations lead to disillusionment and hostility leading to inadequate follow up, dissatisfaction with healthcare services, poor word of mouth, and even choosing to opt out from the host country system altogether. One study reported that close to 80 % of the litigation on hospitals was due to unmet expectations and poor communication [26].

In this context, our study investigated the MT patients' perceptions regarding the quality of intercultural communication by the host country team of doctors on the subject of their treatment. It examined whether their initial clinical experience in the medical interview, including the physical examination, matched their ICC beliefs and expectations in the host country hospital, the Artemis Hospital, situated in Noida, New Delhi. Artemis isa Joint Commission International accredited hospital. Focused on the research paradigm of positivism, the study administered questionnaires originally to 1600 international patients. The study contributes to both theory and practice in communication, culture and MT.

## THEORETICAL FRAMEWORK

Misunderstandings occur when the patients and doctors do not share a common language. This affects clinical interactions regarding symptoms, treatment plans and both pre-operative and post-operative patient care. In this regard the Communication Accommodation Theory [28] was used as a theoretical anchor for this study. Communication accommodation theory (CAT) illustrates how healthcare systems, such as hospitals, prioritized diverse identity groups by considering various micro- and macro-level attributes. These attributes included roles (such as patient and clinician) and professions (such as physician and nursing specializations, including surgical nurse and cardiologist). By emphasizing the intergroup dynamics of health communication, CAT facilitates understanding of patient interactions, interdisciplinary dialogue, and patient education techniques, all of which may enhance medication satisfaction and the delivery of medical treatment. CAT includes sociolinguistic procedures, such as the concepts related to approximating, representativeness, relational control, dialogue management and emotionality, as well as their applications in research on how doctors communicate with patients. The study validated CAT as a useful theory in understanding both the linguistic and sociopsychological aspects of patient-provider medical interactions.

The Communication Accomodation Theory recognised two types of communication styles prevalent across cultures: the convergent communication style and the divergent communication style. Originally concentrated on verbal communication, it now includes aspects related to non-verbal communication as well. In 2014, a study employed the use of the Nonverbal Analysis of Accommodations System, (NAAS), to categorize the nonverbal behaviours of both medical personnel and patients involved in 45 cancer (high severity disease) consultations [29]. Subsequently, each case was

classified into one of seven categories based on the observed patterns of accommodation during the discourse. The findings indicated that, among all NAAS behaviour categories, joint convergence was the most often utilized descriptor for physician–patient interactions, closely followed by asymmetrical–patient convergence. Common instances of cooperative convergence were observed in paraverbal behaviours, including conversation duration, interruptions, and pauses. Eye contact, laughter, and gestures were the nonverbal behaviours most frequently categorized as asymmetrical-physician convergence. Thus, from the point of healthcare communication in an intercultural context, physicians who preferred to adapt to the MT patient communication and prioritised the patients' needs first, used convergent communication style (including both receptive and expressive communication skills, verbal as well as non-verbal). Conversely, physicians who preferred to assert their professional authority and prioritized their own needs used divergent communication style (such as poor listening style, lack of probing questions, poor body language signals, and detachment in general).

We proposed the following hypotheses:

- H1: MT patients' subjective beliefs regarding a destination hospital influences the quality of their clinical experience (in terms of communication accommodation by the doctors)
- H2: MT patients form expectations regarding the destination hospital based on their beliefs regarding a destination hospital
- H3: Expectations of MT patients mediate the relationship between MT patients' ICC beliefs and the quality of ICC experiences in the clinical encounter; unmet expectations can reduce the perception of the quality of experiences

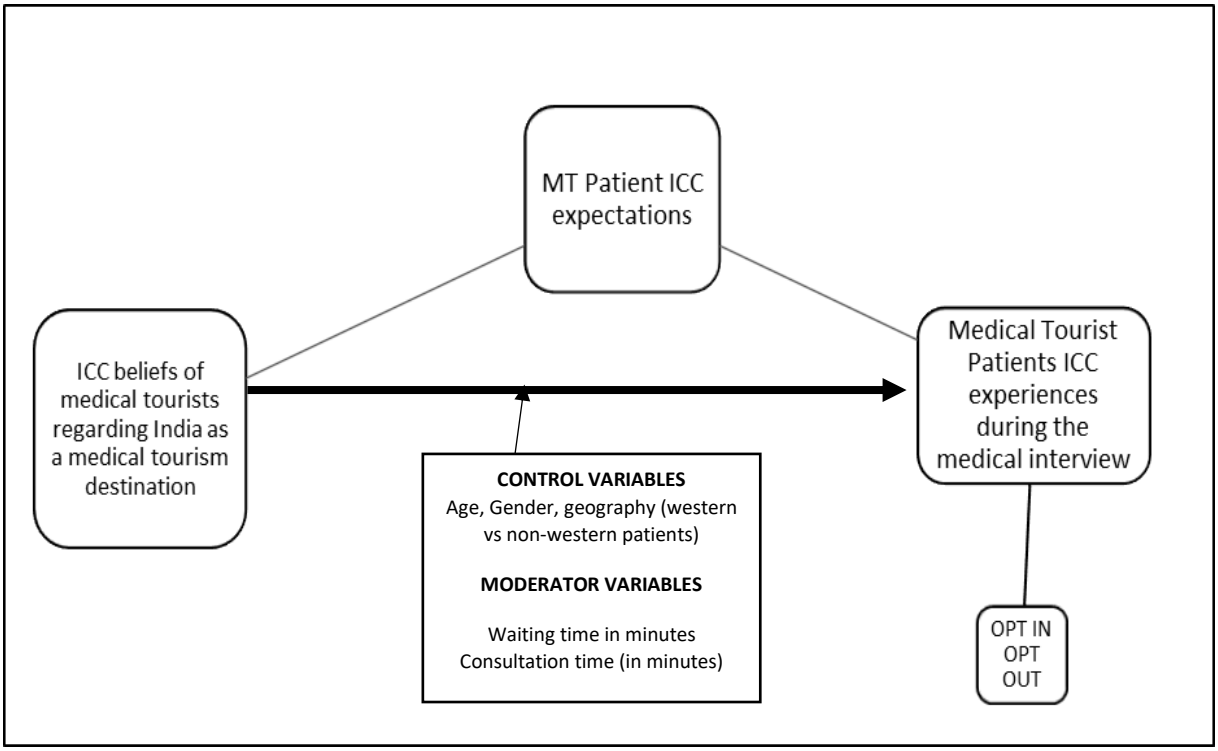
Geography, World Bank ranking of the country of origin, severity of the ailment, and gender of the patient were used as control factors; waiting time and consultation time in minutes were used as moderators in the proposed model. Accreditation status was not considered since this the hospital was accredited by the Joint Commission International (JCI) the certifying body for health care organisations. Participants had also signed forms conforming to the ethico-legal aspects relating to the research design. A Research had revealed that the higher the severity of ailment, the lower the patients' self-reported perception of satisfaction with the hospital. We sought to test this with the sample of MT patients [30] whose severity of the disease (low, medium or high) was cross-checked by the doctor. The World Bank ranking was considered to demarcate low-income countries from the middle- and high-income countries to get a sense of the MT patients' country of origin's gross national income (GNI) per capita. It was expected that patients from prosperous countries would have higher expectations from the Indian MT hospital, than the countries ranked lower in the World bank classification scheme. Extant research studies had pointed out a positive relationship between geographical proximity and cultural affinity [31] and therefore it was expected that non-western patients would report a higher quality of experience in the clinical interaction than the western patients. It was also expected that patients dissatisfied with higher waiting time and lower consultation time would report a lower quality of experience based on our own experience.

The following hypothesis was proposed:

- H4: The proposed model is differentiated by gender, geography, satisfaction with waiting and consultation time, severity of the ailment, and the World Bank classification of economy.

The proposed research model is shown in Figure 1.

**FIGURE 1-THE PROPOSED RESEARCH MODEL**




## DATA COLLECTION AND MEASURES

### RESEARCH APPROACH

A convenient sampling technique was utilized to select participants for the self-reported, questionnaire based, cross-sectional study. Harman's single factor test was used to compute the Common method variance (CMV); the total variance extracted by one factor was 25.34% (A2).

### STUDY CONTEXT AND PARTICIPANT DEMOGRAPHICS

The data collection was conducted at a NABH accredited, GOI approved healthcare institution in New Delhi. Due permission of patients was taken to record their preferences in the questionnaire. Patients of doctors belonging to the following specialisations: Ophthalmology; psychiatry; neurology; cardiology and paediatrics-were considered for this study.

Prior written permission was taken from the hospital authorities to survey the MT patients (vide document number ART/BM/4376).

The participants were originally 1,600 MT patients from 16 different countries, visiting the destination hospital from May 2023-December 2023; 1,474 completed questionnaires were finally used for the study (Table 1). The participants were interviewed by the translators trained for the purpose by the authors. In few cases relatives of the patient helped in answering the questions which were in English language.

TABLE 1. DEMOGRAPHIC PROFILE OF THE MT PATIENTS

| Demographic category | Group 1 | Group 2 | Group 3 | Group 4 |
|---|---|---|---|---|
| **Gender of the MT patient** | **Male** | **Female** | | |
| | 832 | 642 | | |
| **Geography* of the MT patient** | **Western** | **Non-western** | | |
| | 89 | 1385 | | |
| **World bank classification of Economy of the country of belonging of the MT patient** | **Low** | **Middle** | **Upper** | |
| | 1,003 | 347 | 124 | |
| **Severity of ailment of the MT patient** | **Less complicated** | **Moderately complicated** | **Highly complicated** | |
| | 473 | 589 | 412 | |
| **Satisfaction of the MT patient with consultation time** | **Low** | **Moderate** | **High** | |
| | 347 | 147 | 980 | |
| **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 in** | | |
| | 83 | 1,391 | | |

**Indicative list:*
*Western countries: France, Germany, USA, Great Britain, Russia, Uzbekistan*
*Non-western countries: Nigeria, Mauritius, Nepal, Iran, Bangladesh, UAE, S. Arabia, Turkey, Iran, Japan*

### DATA COLLECTION INSTRUMENTS

A pilot testing was done with 300 patents and five doctors using a comprehensive questionnaire in the hospital with the assistance of language translators. Finally, 41 items were retained in the final questionnaire relating to patient beliefs, expectations and their clinical experiences. Data was collected soon after their initial clinical interaction with the host country doctor in the form of exit interviews.

### DATA ANALYSIS TECHNIQUES

Data analysis was performed using a combination of statistical techniques for Confirmatory Factor Analysis and MGA-PLS

## RESULTS AND ANALYSIS

### STUDY ONE

The data was normally distributed. Factor Analysis using the Principal Components Analysis (PCA) method was used for data reduction. The construct, 'MT patient ICC beliefs regarding the Indian MT hospital' revealed three factors: *country and culture beliefs*, *quality of communication accommodation*, and *treatment related beliefs* (Table 2)

**TABLE 2. FACTOR ANALYSIS FOR THE CONSTRUCT: ICC RELATED BELIEFS OF MT PATIENTS REGARDING THE INDIAN MT HOSPITAL (N=12 INDICATORS)**

| Sn | Rotated Component Matrix[a] | | | |
|---|---|---|---|---|
| | ICC related beliefs of MT patients regarding the Indian MT hospital | Component/ Factor | | |
| | | Country and culture beliefs | Communication accommodation by the hospital | Treatment related beliefs |
| 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.<br>Rotation Method: Varimax with Kaiser Normalization. | | | |
| | Rotation converged in 8 iterations.<br>Total variance explained=58.700 | | | |

The Factor Analysis using the PCA on MT patient clinical experience revealed four factors viz., communication accommodation, listening behaviour, language or code-switching behaviour, and expressive communication behaviour. It sought to operationalise the convergent and divergent communication shown by the doctors and which factors contributed the most to the patient perception of doctors' ICC accommodation behaviours (Table 3)

**TABLE 3. FACTOR ANALYSIS FOR THE CONSTRUCT: ICC RELATED EXPERIENCES OF MT PATIENTS IN CLINICAL INTERACTIONS THE INDIAN MT HOSPITAL (N=17 INDICATORS)**

| | Rotated Component Matrix[a] | | | | |
|---|---|---|---|---|---|
| 1 | The hospital /attending team of physicians/Items | Communication accommodation | Listening 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.<br>Rotation Method: Varimax with Kaiser Normalization. | | | | |
| | a. Rotation converged in 6 iterations.<br>Total variance explained: 61.041 | | | | |

The Factor Analysis using the PCA for the construct MT patient expectations (mediator) resulted in four factors, viz., expressive communication skills, cultural sensitivity in medical processes, and receptive communication style (Table 4).

**TABLE 4. FACTOR ANALYSIS FOR THE CONSTRUCT: ICC RELATED EXPECTATIONS OF MT PATIENTS FROM THE INDIAN MT HOSPITAL (N=27 INDICATORS)**

| 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.<br>Rotation Method: Varimax with Kaiser Normalization. | | | |
| | a. Rotation converged in 6 iterations.<br>Total variance explained: 58.078 | | | |

## THE GLM MULTIVARIATE

The General Linear Model served as a multi regression statistical tool to determine statistical association between the dependent mediator, moderator and independent variables. Table 5-1 displays the four significance tests for each model.

**TABLE 5-1. RESULTS OF GLM ANALYSIS**

Multivariate Tests[a]

| Effect | | Value | F | Hypothesis df | Error df | Sig. | Partial Eta Squared | Noncent. Parameter | Observed Power[c] |
|---|---|---|---|---|---|---|---|---|---|
| **Intercept** | Pillai's Trace | .000 | .000[b] | 4.000 | 1467.000 | 1.000 | .000 | .000 | .050 |
| | Wilks' Lambda | 1.000 | .000[b] | 4.000 | 1467.000 | 1.000 | .000 | .000 | .050 |
| | Hotelling's Trace | .000 | .000[b] | 4.000 | 1467.000 | 1.000 | .000 | .000 | .050 |
| | Roy's Largest Root | .000 | .000[b] | 4.000 | 1467.000 | 1.000 | .000 | .000 | .050 |
| **FAC1_2 Beliefs regarding country and culture** | Pillai's Trace | .742 | 1053.560[b] | 4.000 | 1467.000 | <.001 | .742 | 4214.240 | 1.000 |
| | Wilks' Lambda | .258 | 1053.560[b] | 4.000 | 1467.000 | <.001 | .742 | 4214.240 | 1.000 |
| | Hotelling's Trace | 2.873 | 1053.560[b] | 4.000 | 1467.000 | <.001 | .742 | 4214.240 | 1.000 |
| | Roy's Largest Root | 2.873 | 1053.560[b] | 4.000 | 1467.000 | <.001 | .742 | 4214.240 | 1.000 |
| **FAC2_2** | Pillai's Trace | .824 | 1711.423[b] | 4.000 | 1467.000 | <.001 | .824 | 6845.693 | 1.000 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Beliefs regarding cultural accommodation** | Wilks' Lambda | .176 | 1711.423[b] | 4.000 | 1467.000 | <.001 | .824 | 6845.693 | 1.000 |
| | Hotelling's Trace | 4.666 | 1711.423[b] | 4.000 | 1467.000 | <.001 | .824 | 6845.693 | 1.000 |
| | 8Roy's Largest R9oot | 4.666 | 1711.423[b] | 4.000 | 1467.000 | <.001 | .824 | 6845.693 | 1.000 |
| **FAC3_2 Cognitive ICC beliefs related to treatment in the hospital** | Pillai's Trace | .678 | 771.220[b] | 4.000 | 1467.000 | <.001 | .678 | 3084.882 | 1.000 |
| | Wilks' Lambda | .322 | 771.220[b] | 4.000 | 1467.000 | <.001 | .678 | 3084.882 | 1.000 |
| | Hotelling's Trace | 2.103 | 771.220[b] | 4.000 | 1467.000 | <.001 | .678 | 3084.882 | 1.000 |
| | Roy's Largest Root | 2.103 | 771.220[b] | 4.000 | 1467.000 | <.001 | .678 | 3084.882 | 1.000 |
| a. Design: Intercept + FAC1_2 + FAC2_2 + FAC3_2 | | | | | | | | | |
| b. Exact statistic | | | | | | | | | |
| c. Computed using alpha = .05 | | | | | | | | | |

The multinomial regression showed that the Wilks' λ value was closer to 0 for the three MT belief factors indicating the strength of the relationship between patient belief and experience. Of the three, *communication accommodation behaviours* of the hospital team ranked significantly higher for influencing MT patient ICC clinical experiences. Pillai's trace and Hotelling's trace were positively valued with increasing values indicating effects that contributed more to the model; MT patient' ICC beliefs regarding communication accommodation had higher values showing that it contributed more to the model than other two factors (p> 0.05).

The larger partial eta squared values show the extent of variance explained by that variable/factor in the model (Table 5-2).

**TABLE 5-2. RESULTS OF GLM ANALYSIS (TESTS OF BETWEEN-SUBJECTS EFFECTS)**

| Source | Dependent Variable | Type III Sum of Squares | df | Mean Square | F | Sig. | Partial Eta Squared | Noncent. Parameter | Observed Power[e] |
|---|---|---|---|---|---|---|---|---|---|
| **Corrected Model** | Experience factor 1 Communication accommodation | 812.097[a] | 3 | 270.699 | 602.096 | <.001 | .551 | 1806.288 | 1.000 |
| | Experience factor 2 Receptive communication behaviours | 579.398[b] | 3 | 193.133 | 317.708 | <.001 | .393 | 953.125 | 1.000 |
| | Experience factor 3 Code switching by the doctors/staff | 145.919[c] | 3 | 48.640 | 53.878 | <.001 | .099 | 161.634 | 1.000 |
| | Experience factor 4 Expressive communication behaviours | 130.554[d] | 3 | 43.518 | 47.653 | <.001 | .089 | 142.958 | 1.000 |
| **Intercept** | Experience factor 1 Communication accommodation | .000 | 1 | .000 | .000 | 1.000 | .000 | .000 | .050 |
| | Experience factor 2 | .000 | 1 | .000 | .000 | 1.000 | .000 | .000 | .050 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Receptive communication behaviours | | | | | | | | |
| | Experience factor 3 Code switching by the doctors/staff | .000 | 1 | .000 | .000 | 1.000 | .000 | .000 | .050 |
| | Experience factor 4 Expressive communication behaviours | .000 | 1 | .000 | .000 | 1.000 | .000 | .000 | .050 |
| **FAC1_2 Beliefs regarding country and culture** | Experience factor 1 Communication accommodation | 169.437 | 1 | 169.437 | 376.867 | <.001 | .204 | 376.867 | 1.000 |
| | Experience factor 2 Receptive communication behaviours | 237.056 | 1 | 237.056 | 389.963 | <.001 | .210 | 389.963 | 1.000 |
| | Experience factor 3 Code switching by the doctors/staff | 5.224 | 1 | 5.224 | 5.786 | .016 | .004 | 5.786 | .671 |
| | Experience factor 4 Expressive communication behaviours | 47.927 | 1 | 47.927 | 52.481 | <.001 | .034 | 52.481 | 1.000 |
| **FAC2_2 Beliefs regarding cultural accommodation** | Experience factor 1 Communication accommodation | 605.156 | 1 | 605.156 | 1346.005 | <.001 | .478 | 1346.005 | 1.000 |
| | Experience factor 2 Receptive communication behaviours | 43.832 | 1 | 43.832 | 72.105 | <.001 | .047 | 72.105 | 1.000 |
| | Experience factor 3 Code switching by the doctors/staff | 140.689 | 1 | 140.689 | 155.841 | <.001 | .096 | 155.841 | 1.000 |
| | Experience factor 4 Expressive communication behaviours | 12.873 | 1 | 12.873 | 14.096 | <.001 | .009 | 14.096 | .963 |
| **FAC3_2 Cognitive ICC beliefs related to treatment in the hospital** | Experience factor 1 Communication accommodation | 37.503 | 1 | 37.503 | 83.416 | <.001 | .054 | 83.416 | 1.000 |
| | Experience factor 2 Receptive communication behaviours | 298.510 | 1 | 298.510 | 491.057 | <.001 | .250 | 491.057 | 1.000 |
| | Experience factor 3 Code switching by the doctors/staff | .006 | 1 | .006 | .007 | .932 | .000 | .007 | .051 |
| | Experience factor 4 | 69.753 | 1 | 69.753 | 76.380 | <.001 | .049 | 76.380 | 1.000 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Expressive communication behaviours | | | | | | | | |
| **Error** | Experience factor 1 | 660.903 | 1470 | .450 | | | | | |
| | Experience factor 2 | 893.602 | 1470 | .608 | | | | | |
| | Experience factor 3 | 1327.081 | 1470 | .903 | | | | | |
| | Experience factor 4 | 1342.446 | 1470 | .913 | | | | | |
| **Total** | Experience factor 1 | 1473.000 | 1474 | | | | | | |
| | Experience factor 2 | 1473.000 | 1474 | | | | | | |
| | Experience factor 3 | 1473.000 | 1474 | | | | | | |
| | Experience factor 4 | 1473.000 | 1474 | | | | | | |
| **Corrected Total** | Experience factor 1 | 1473.000 | 1473 | | | | | | |
| | Experience factor 2 | 1473.000 | 1473 | | | | | | |
| | Experience factor 3 | 1473.000 | 1473 | | | | | | |
| | Experience factor 4 | 1473.000 | 1473 | | | | | | |
| e. Computed using alpha = .05 | | | | | | | | | |

*Beliefs regarding country and culture* explained much of the variance in Communication accommodation and *Receptive communication behaviours*. Experience factor 1 and 2 (*Cultural accommodation and Receptive communication behaviours*) displayed high R-square values (Adjusted R Squared = .550; Adjusted R Squared = .392) whereas Experience factor 3 and 4 (Code switching by the doctors/staff and Expressive communication behaviours) displayed low R square values (Adjusted R Squared = .097; Adjusted R Squared = .087), indicating that these did not contribute to the model.

## PARAMETER ESTIMATES

The effect of each predictor is summarised in the parameter estimates table. MT patients' beliefs relating to the *Country and culture* was found to significantly influence the dependent variable *Communication accommodation*. Results show that except treatment cost, all factors contributed significantly to the model (Table 5-3)

**TABLE 5-3. RESULTS OF GLM ANALYSIS -PARAMETER ESTIMATES**

| Dependent Variable | Parameter | B | Std. Error | t | Sig. |
|---|---|---|---|---|---|
| **Experience factor 1 Communication accommodation** | Intercept | -4.359E-17 | .017 | .000 | 1.000 |
| | Belief in Indian MT FAC1_2 country and culture | .339 | .017 | 19.413 | <.001 |
| | Belief in Indian MT FAC2_2 Cultural accommodation | .641 | .017 | 36.688 | <.001 |
| | Belief in Indian MT FAC3_2 Treatment cost | .160 | .017 | 9.133 | <.001 |
| **Experience factor 2 Receptive communication behaviours** | Intercept | 3.787E-17 | .020 | .000 | 1.000 |
| | Belief in Indian MT FAC1_2 country and culture | .401 | .020 | 19.747 | <.001 |
| | Belief in Indian MT FAC2_2 Cultural accommodation | .173 | .020 | 8.491 | <.001 |
| | Belief in Indian MT FAC3_2 Treatment cost | .450 | .020 | 22.160 | <.001 |
| **Experience factor 3 Code switching** | Intercept | -4.309E-17 | .025 | .000 | 1.000 |

| | | | | | |
|---|---|---|---|---|---|
| | Belief in Indian MT FAC1_2 country and culture | -.060 | .025 | -2.405 | .016 |
| | Belief in Indian MT FAC2_2 Cultural accommodation | .309 | .025 | 12.484 | <.001 |
| | Belief in Indian MT FAC3_2 Treatment cost | .002 | .025 | .085 | .932 |
| **Experience factor 4 Receptive communication behaviours** | Intercept | -1.093E-16 | .025 | .000 | 1.000 |
| | Belief in Indian MT FAC1_2 country and culture | .180 | .025 | 7.244 | <.001 |
| | Belief in Indian MT FAC2_2 Cultural accommodation | .093 | .025 | 3.755 | <.001 |
| | Belief in Indian MT FAC3_2 Treatment cost | .218 | .025 | 8.740 | <.001 |

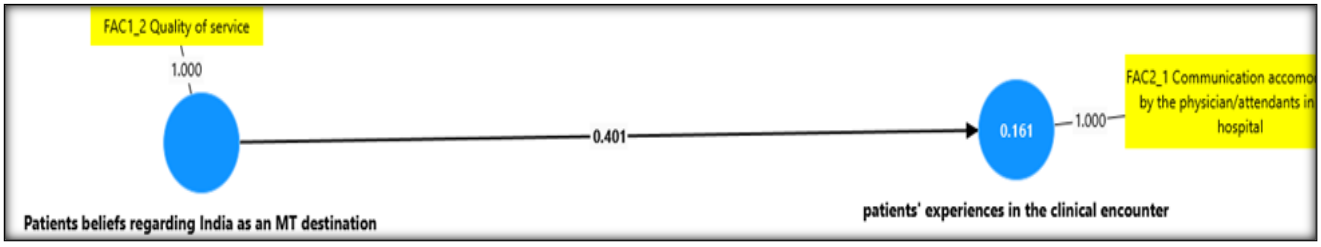
Study 1, based on Factor Analysis and the GLM, concluded that the MT patients' beliefs about the culture of the country and the hospital services influenced their quality of clinical experience. MT patients' expectations were largely derived from these set of ICC beliefs and these expectations mediated the relationship between patients' ICC beliefs and patients' ICC experiences. Study 2 was conducted to further test for the validity and reliability of the GLM output.

## STUDY 2

The outputs of the Factor Analysis factors were then transferred to the Smart PLS to run the CFA and the mediator analysis. The SPSS file containing the values were uploaded on smart PLS to test endogenous constructs that contributed most to the model. Derived from the Factor Analysis (PCA), these were identified as formative constructs in Smart PLS.

For factor indicators, only values above .700 were accepted. Consequently, only one factor in each construct significantly contributed to the model (Figure 2). The independent variable was FAC1_2, in the construct, *Belief in the country and culture of Indian MT hospital* (comprising five items: I am aware of health risks in new country; I believe that Indian hospitals are sensitive to patient concerns; I believe that cultural disparities are accounted for in the hospital; I am conscious about gender; and I believe I am knowledgeable about the characteristics of the treating hospital. The dependent variable was FAC 2_1, belonging to the construct *Quality of patient experience in the clinical encounter* (Communication accommodation by the attending team) comprising seven items: The hospital /attending team of physicians appointed a language translator; was adept in handling queries; educated me about medical issue; advised change in health behaviours; showed concern; made eye contact; and performed a culturally sensitive physical examination (PE)

**FIGURE 2-RESULTS OF THE MEASUREMENT MODEL**




Source: Smart PLS

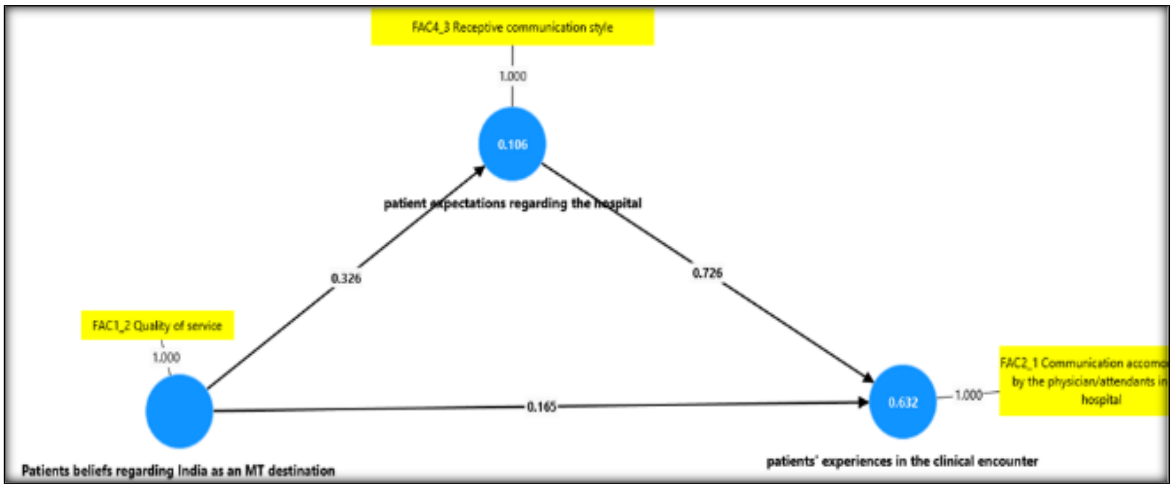
Table 6 shows the values of the quality tests, before and after adding the mediator variable (expectations regarding the receptiveness of the team, comprising two items: listening and responsive eye contact):

**TABLE 6. VALUES OF QUALITY CRITERION BEFORE AND AFTER ADDING THE MEDIATOR VARIABLE**

| 1 | **Path Coefficients: Before adding the Mediator** | | | **Path coefficients: After adding the mediator** |
|---|---|---|---|---|
| | **Constructs** | **Dependent Construct** (ICC experience of MT patients regarding Communication accommodation) | **Independent construct** (ICC belief of MT patient regarding the Indian hospital as MT hub) | **Mediator** (Expectations regarding the receptive communication behaviour of the team) |
| | ICC experience of MT patients regarding Communication accommodation (dependent variable) | 1 | | |
| | ICC belief of MT patient regarding the Indian hospital as MT hub (independent construct) | | 0.401 | 0.165 |
| **2** | **R-square: Before the mediator** | | | **R-square: After the mediator** |
| | Experience of MT patients-behavioural ICC | 0.160 | | 0. 631 |
| **3** | **f-square: Before the mediator** | | | **f-square: After the mediator** |
| | Mt patients' ICC beliefs Indian hospitals as MT hub -> experience of MT patients-communication accommodation | 0.192<br><br>*(Note: Recommended f2 cut offs are 0.02, 0.15, and 0.35 for small, medium, and large effect sizes respectively.* | | 0.066 |

Partial mediation was indicated by patients' expectations (value of path coefficient decreased from 0.401 to 0.165). The model also shows robustness after adding the mediator (the R square increased to 0.631). Figure 3 displays the final model:

**FIGURE 3- FINAL RESEARCH MODEL**




Source: Smart PLS

*Structural Model.* Bootstrapping for N=10,000 sample showed increase in the R square values (Table 7). The $Q^2$ values obtained by the blindfolding procedure in PLS-SEM was positive, indicating that the model enjoyed predictive relevance.

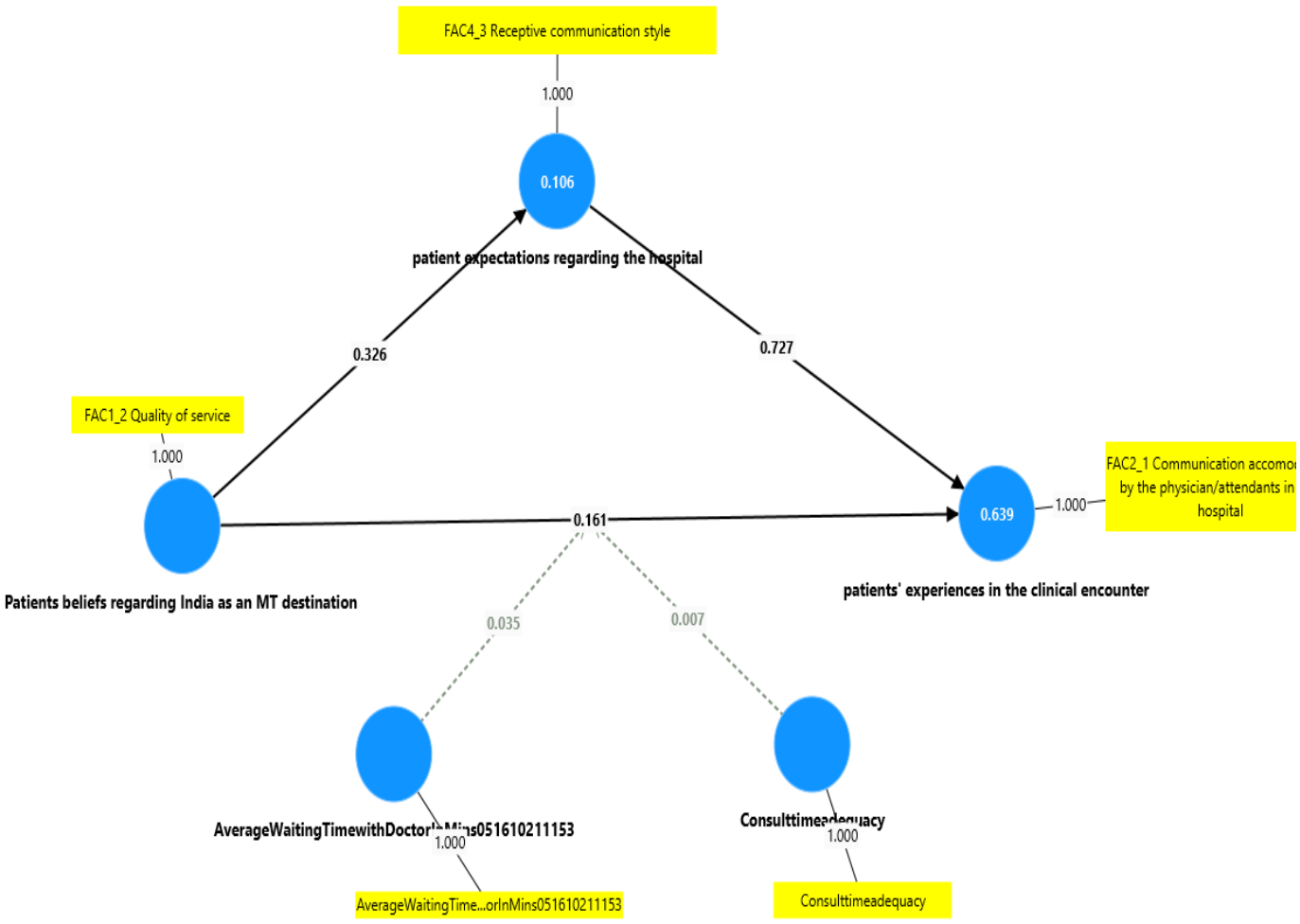
**TABLE 7. COMBINED RESULTS OF THE MEASUREMENT AND STRUCTURAL MODEL**

| | | | | | | |
|---|---|---|---|---|---|---|
| **1** | **Path Coefficients: Before adding the Mediator** | | | **Path coefficients: After adding the mediator** | **Bootstrapping** | **Blindfolding** |
| | **Constructs** | **Dependent Construct** (ICC experience of MT patients regarding Communication accommodation by the hospital team) | **Independent construct** (ICC belief of MT patient regarding the Indian hospital as a reliable MT hub) | **Mediator** (Expectations regarding the receptive communication behaviour of the team) | | |
| | ICC experience of MT patients regarding Communication accommodation (dependent variable) | 1 | | | | |
| | ICC belief of MT patient regarding the Indian hospital as MT hub (independent construct) | | 0.401 | 0.165 | | |
| **2** | **R-square: Before the mediator** | | | **R-square: After the mediator** | **R-square: After Bootstrapping** | |
| | ICC Experience of MT patients in communication accommodation | 0.160 | | 0. 631 | 0.631; T-stat: 43.992; p=0.000<.05 | |
| **3** | **f-square: Before the mediator** | | | **f-square: After the mediator** | **f-square: After Bootstrapping** | |
| | Mt patients' ICC beliefs Indian hospitals as MT hub -> experience of MT patients-communication accommodation | 0.192<br><br>*(Note: Recommended f2 cut offs are 0.02, 0.15, and 0.35 for small, medium, and large effect sizes respectively.* | | 0.066 | 1.277; T stat=14.220; p=0.000<.05 | |
| 4 | **HTMT-Monotrait** | | | | 2.5% 0.759<br>97.5% 0.798 | |
| 5 | Communication accommodation perceived by the MT patients | | | **$Q^2$** | | 0.159 |

| | | | |
|---|---|---|---|
| | | | (Note: Moderate Predictive relevance) |

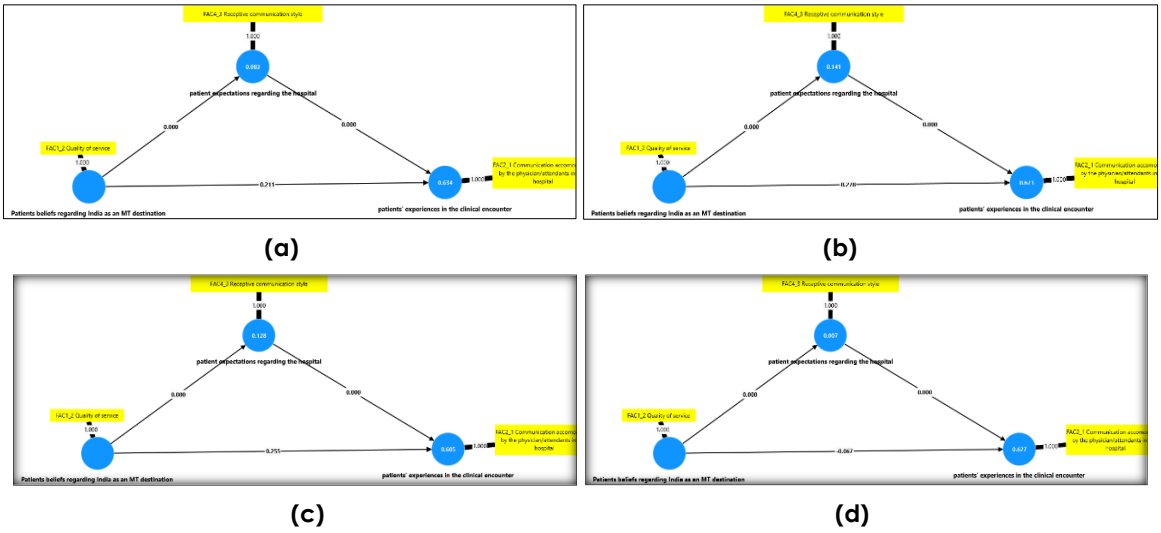
The Multigroup analysis (MGA) revealed that overall, the model was not differentiated for any of the moderator variables (waiting time, and consult time), and nor for any control groups such as gender, geography, economic status, and severity of the disease. However, the difference was significant between two groups of wait time (Group_1 *403 MT patients; less than 5 minutes* - Group_2 *510 MT patients; between 6-10 minutes = -0.056;* (Group_1 vs Group_2) p value=0.000 <.01)

**FIGURE 4-MODERATOR ANALYSIS OUTPUT**




The Multi-group analysis (Figure 5) shows that patients in Group 3 showing high satisfaction with consultation time improved the model, than patients with low satisfaction with consultation time; patients in Group 2 belonging to western countries improved the model than patients belonging to non-western countries; patients in Group 4 with high severity of disease improved the model than patients with less complicated medical problems; and that Group 3 (patients least satisfied with waiting time) contributed most negatively to the model.

FIGURE 5-MGA OUTPUTS FOR (A) CONSULT TIME (B) GEOGRAPHY (C) SEVERITY OF DISEASE (D) WAIT TIME




## DISCUSSION

Significant differences were found to exist between the western and the non-western countries with regard to patient communicative experiences in the clinic. This corroborates the findings of earlier studies [9,10, 14]. The beliefs systems regarding the host country hospitals influenced outcomes such as a self-reported poor clinical experience in this study [15,16,17,18]. Our study supports the assertion that medical tourist expectations need to be documented and managed [see 25]. The study validated CAT as a useful theory in understanding both the linguistic and sociopsychological aspects of patient-provider medical interactions. The accommodation practices by the doctors were mainly found to be divergent in our study and it affected the quality of clinical experiences [28] of the MT patients. Both verbal and non-verbal communication accommodation practices by doctors were found to be insufficient in our study. Our study supports the findings of the NAAS survey [29] wherein also asymmetrical accommodation was found in doctor-patient interactions for severe ailments

The results showed that developing confidence among the MT patients is important for building trust in the host country hospital in the medical tourism sector. A high level of confidence in the communication and cultural accommodation practices followed by the destination hospital influenced the quality of the MT patients' initial clinical encounters (Hypothesis 1). Patients perceived a positive experience when the attending team of doctors convergently accommodated by way of arranging language translators, handling patient queries patiently, listening to them, showing positive body language behaviours, educating patients about their medical issues, demonstrating verbal concern , using proper eye contact, advising change in health behaviours in accordance with their culture and religion, and more importantly, performing a culturally sensitive physical examination (PE) respecting gender preferences (Hypothesis 2). However, divergent accommodation, characterised by fewer questions raised by the doctors, poorly responding to the patient queries, and low expressive skills of the attending team negatively influenced their experience in the clinical encounter.

Expectations are internally manifested by the patients and depend on a number of factors such as word of mouth promotion by other patients. Results show that patients develop expectations about the MT services based on their beliefs, which, in turn, influenced the quality of their experiences. The mediation analysis revealed that patient expectations regarding the receptive communication abilities of the host country team of doctors mediated the relationship between MT patient beliefs and MT patient experiences (Hypothesis 3) ultimately enhancing overall satisfaction and health outcomes. In other words, higher expectations enhanced the in-clinic experience of the patients; conversely lower expectations reduced the quality of clinical interactions. The hospital can nurture positive expectations by talking about

the brand of the hospital in a positive manner, promoting their hospital brand, recounting of success stories, and highlighting the cultural richness of the place. This is important because medical tourism is more than just tourism; it is also travel and hospitality arrangements made by the hospital where culture is inexplicably drawn in. (Hypotheses 1 and 2).

Our study showed that the non-western patients had higher expectations from Indian doctors regarding cultural and communication accommodation than western patients. This could be due to assumptions regarding communication and cultural similarities and the geographical proximity of their respective countries to India. Patients belonging to countries with high cultural affinity with the host country in terms of collectivism, patriarchal culture and collaborative decision making expected more 'family like' behaviour from the Indian doctors rather than a professional demeanour.

Patient dissatisfaction with waiting time and severity of the disease have the potential to positively or negatively influence the quality of experience. The patients with least waiting time recorded better experience than patients with the highest wait time in this study. The moderation analysis using satisfaction with the wait time and consult time did not reveal any significant results (Hypothesis 4). Consultation time, while overall a poor differentiator, negatively influenced the experience for patients who had less than five minutes of consult time with the attending team of host country doctors.

The model was controlled for gender, geographies, severity of the illness, and economic status of the countries, but no significant differentiation was found across categories. This hints at influence of other determinants of overall quality of experience in the host country hospitals. The MGA results, however cannot be ignored, because patients with more severe ailments expected more communication and cultural sensitivity from the attending team of doctors at the hospital than patients with low or moderate severity of ailments

## CONCLUSION

Expectation Management (EM) is emerging as a critical field in doctor-patient interactions especially in the case of Medical Tourism. It is not enough to obtain accreditation; hospitals should ensure that the administrative processes in terms of patient expectations regarding hospital facilities, tourism opportunities, stay of relatives, socio-religious cultural accommodation, and related services are met accordingly. Our study shows that the hospital can benefit from conducting cross-cultural training programs to enhance service quality and patient experience in the clinical interaction. Doctors need information on gender sensitivities, touch, eye contact, and more, especially when dealing with non-western patients

Raising expectations has a domino effect on raising perception of quality of service. This may be done by investing in promotion of the hospital services to build confidence in the MT patients regarding the hospital selected by them. The study recommends investing in building MT websites, providing evidence of cognitive, affective, and behavioural expertise of Indian hospitals in treating MT patients. For instance, simulations based on augmented reality (AR) and Virtual Reality (VR) technologies may be used to display nuances of doctor-patient communication in an intercultural communication context. Similarly, concerns regarding gender preferences especially for physical examination and drawing up of culturally aligned prescription plans may be addressed through these websites by means of referrals, videos, pictures, and other promotional materials.

### LIMITATIONS AND FUTURE WORK

The study is not without its limitations. First, it was conducted in one hospital which significantly limited the generalisability of the findings. Secondly it relied on self-reported data from patients with the help of language translators. Many minor points might have been 'lost in translation' even as the data was captured as soon as the patient had exited from the clinical venue. Thirdly, the data was cross sectional rather than longitudinal. Results might vary according to context and time. Scholars working on this area can overcome these limitations by adding data from more accredited hospitals in one country or across different countries. They may also choose to conduct a longitudinal study on patients from select countries over multiple consultations with a focus beyond culture and communication.

## LIST OF ABBREVIATIONS USED

MT: Medical Tourism
NABH: National Accreditation Board for Hospitals & Healthcare Providers
JCI: Joint Commission International
EM: Expectation Management
CAT: Communication Accommodation Theory
ICC: Inter-Cultural Communication
PE: Physical Examination
MGA: Multi Group Analysis

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## APPENDIX

### A1: COPY OF THE PATIENT QUESTIONNAIRE

Dear patients

This is to solicit your opinions on communication, cultural beliefs, expectations, and experiences in this hospital. Request your kind cooperation. We assure you that all information will be kept confidential, and that the data is used for the research purposes only. The study has duly been approved by the Hospital Administration. Thank you

- Name-
- Nationality-
- First Language-
- Age: (25-35) (36-45) (46-55) (56-65) (66-75)
- Gender: (1) Male (2) Female
- I have consulted this hospital before (1) Yes (2) No
- I have been recommended to visit this hospital (1) Through social media (2) Friends/Relatives (3) Resident doctor of my country (4) Popular media (5) Others such as ……
- The medical interview time with the doctor was 0-5 minutes; 6-10 minutes 11-15 minutes 16-30 minutes; above 30 minutes
- The waiting time on an average with the doctor was 0-5 minutes; 6-10 minutes 11-15 minutes 16-30 minutes; above 30 minutes
- The average waiting time was (a) too less (b) moderate (c) adequate
- The medical interview time was (a) too less (b) moderate (c) adequate
- I was satisfied with the medical interview (a) No (b) Yes
- I requested for more consultation time / consultation with other experts in this hospital before taking a decision to opt for this hospital (a) No (b) Yes
- I opted for medical treatment in this hospital (a) No (b) Yes
- My treatment went on for (a) 1-3 months (b) 4-8 months (c) 8 months and above

**Q2 Rate the importance of the following in your choice of treatment on a scale of 1-10**

1 2 3 4 5 6 7 8 9 10

**Not at all** **Extremely important**

- The doctor's racial and ethnic identity
- The gender of the doctor based on our culture's practice and acceptability
- The characteristics of the treating hospital (location, region, competency, expertise)
- The doctor's experience with patients/health care professionals from culturally diverse backgrounds
- The cultural differences/ disparities in deciding treatment in a foreign country (for yourself)
- The health risks experienced by patients belonging to diverse racial and ethnic groups in medical treatment
- The sensitivity of the physicians on issues related to children, adults (especially women from different countries, religions and cultures)
- The flexibility of the doctor to my concerns
- The doctor's knowledge about the different healing traditions (e.g., Ayurvedic Medicine, Traditional Chinese Medicine, and Allopathic treatments) and especially those practiced in my culture
- The treatment cost and expense of stay of patient and relatives
- The medical record language spoken in the hospital

**Q3 Rate your self-beliefs on a scale of 1-10 about the following statements:**

1 2 3 4 5 6 7 8 9 10

**Totally Disagree** **Totally Agree**

- I have considerable knowledge about the different healing traditions (e.g., Ayurvedic Medicine, Traditional Chinese Medicine, Allopathic Medicine)
- I am highly aware about my own cultural identity, stereotypes and prejudices
- I researched heavily about India's culture, its beliefs and ways of doing things in healthcare before coming to India
- The healthcare professionals must compulsorily receive training in cultural diversity and/or multicultural health care
- India is a good hub of reliable medical tourism

**Q4 Rate the expectations from a doctor in medical tourism during consultation on a scale of 1-10**

1 2 3 4 5 6 7 8 9 10

**Totally Disagree** **Totally Agree**

- Small talk about family, food, culture, and country
- Explain the problem in my language/language I understand
- Listen to me without interruptions
- Make eye contact
- Show concern
- Perform a culturally sensitive physical examination
- Prescribe/negotiate a culturally sensitive treatment plan
- Educate me about the problem using proper mediums
- Appoint a language translator with knowledge of my cultural background
- Adept in handling questions
- Deal confidently with objections in a culturally sensitive manner
- Identify cultural beliefs that are not expressed but might interfere with the treatment regimen
- Apologies if cultural gaffes are made
- Demonstrates knowledge about interpreting different cultural expressions of pain, distress, and suffering
- Advises a patient to change behaviours or practices related to cultural beliefs that impair one's health

**Q5 Rate the body language expectations from a doctor in medical tourism on a scale of 1-10**

1 2 3 4 5 6 7 8 9 10

**Not at all** **Extremely Skilled**

- Physicians should be aware of greeting patients in a culturally sensitive manner
- Physicians should make a good eye contact with the patient
- Physicians should be direct and forthright
- Physicians should convey the bad news directly and quickly
- Physicians should be formal in saying good-byes
- Physicians should always be punctual for an appointment; being late is unprofessional
- Physicians should strictly adhere to meeting time
- Physicians should always be well dressed ensuring adherence to safety concerns
- Physicians should always be pleasant and be smiling when consulting the patient
- Physicians should always be informal and relaxed with the international patients
- Physicians should talk clearly and loudly with the international patients

- Physicians should write prescriptions which are legible
- Physicians should use culturally specific gestures that might have different meanings in different cultures

**Q6 Rate the actual experience during consultation in this hospital on a scale of 1-10**



1 2 3 4 5 6 7 8 9 10

**Totally Disagree** **Totally Agree**

- Indulged in small talk about family, food, culture, and country
- Explained the problem in my language/language I understand
- Listened to me without interruptions
- Made eye contact
- Showed concern
- Performed a culturally sensitive physical examination
- Prescribed/negotiated a culturally sensitive treatment plan
- Educated me about the problem using proper mediums
- Appointed a language translator with knowledge of my cultural background
- Were adept in handling questions
- Dealt confidently with objections in a culturally sensitive manner
- Identified cultural beliefs that are not expressed but might interfere with the treatment regimen
- Made cultural mistakes
- Apologized when these mistakes were made
- Demonstrated knowledge about interpreting different cultural expressions of pain, distress, and suffering
- Advised changing behaviours or practices related to cultural beliefs that impair one's health

## A2: CMV OUTPUT

| Total Variance Explained | | | |
|---|---|---|---|
| Factor | Extraction Sums of Squared Loadings | | |
| | Total | % Of Variance | Cumulative % |
| 1 | .760 | 25.344 | 25.344 |
| Extraction Method: Maximum Likelihood. | | | |