

Chapter 4

First rehabilitation consultation in patients of
non-native origin: Factors that lead to tension in
the patient physician interaction

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Disability and Rehabilitation 2009; 31 (22): 1853-1861.

Abstract

Purpose

To explore which factors lead to tension in the patient-physician interaction in the first consultation by rehabilitation physicians of patients with chronic non-specific low back pain of Turkish and Moroccan origin.

Method

In-depth semi-structured, face to face interviews were conducted with twelve patients of Moroccan and Turkish origin and four native Dutch rehabilitation physicians. Interviews were transcribed and/or summarised. All interviews were subsequently coded and analysed according to themes.

Results

Factors that lead to tension in the patient physician interaction were as follows: differences in expectations regarding the aim of treatment, symptom presentation, views on responsibilities with regard to rehabilitation treatment, lack of trust, contradicting views of physicians from patients' country of origin with regard to the cause and treatment of pain, and communication problems.

Conclusion

Sources of tension were identified during the interaction between Dutch physicians and patients of Turkish and Moroccan origin. These factors potentially are associated with future drop-out. Future research should clarify whether these factors indeed are associated with drop-out.

Introduction

Drop-out of healthcare programmes often occurs in non-native patients (1-3). Previous studies in patients with chronic (low back) pain who participated in a rehabilitation programme found drop-out rates ranging from 10%-42%(4-6). Drop-out from chronic low back pain rehabilitation treatment in non-native patients (28.1%) in The Netherlands has been reported to be twice as high as in native Dutch patients (13.7%) (7). There is limited knowledge of the causes of this higher drop-out.

The present article focuses on the interaction between native Dutch rehabilitation physicians and non-native patients from a different cultural background as source of tension, which potentially leads to drop-out of patients from rehabilitation treatment.

To understand the way patients cope with illness and its treatment, Kleinman introduced the explanatory belief model (8). Explanatory models are ideas about illness events, the diagnosis and treatment of the illness. Patient and physician have different ideas and knowledge about health and disease and they have different interests in health care. These differences are expressed in an individual's explanatory model of health and disease (8). The difference between the (cultural) background of the patient and physician contributes to differences of opinion on the cause of illness and the way it has to be treated. This contrasting perspective could disrupt the patient-provider interaction and cause drop-out of the prescribed treatment.

There are many factors that can explain drop-out of patients. A review showed a wide variety of factors which potentially cause drop-out (9). Potential drop-out factors occur at three levels: patient-, provider- and system level. The patient level refers to patient related characteristics (e.g. education and income), which determine how people make use of the healthcare system. The provider level refers to provider characteristics (e.g. skills and attitudes), which determine how health care is provided by professionals. The system level represents the system characteristics (e.g. policy and organizational factors), which determine how the care is organized around the patient. Barriers on all three levels may influence the interaction between patient and physician: barriers at patient-, provider- or system level potentially disrupt the interaction between patient and physician, leading to tension and drop out.

This study aimed to explore which factors lead to tension in the patient physician interaction in the first consultation by rehabilitation physicians of patients with chronic

non-specific low back pain of Turkish and Moroccan origin. The interviews were held directly after the first consultation with the physician in order to find opinions of patients that were not yet distorted by events during the rehabilitation process. Patients with chronic non-specific low back pain and their physicians were interviewed on the course and content of the consultation.

Methodology

Design

A qualitative research method was used to explore notions and beliefs of patients and physicians. The interviews were held directly after the first consultation with the physician.

Participants

Participants consisted of patients of Turkish and Moroccan origin and native Dutch rehabilitation physicians. This study focused on patients of Turkish and Moroccan origin because these patients belong to the two largest groups of non-native patients in The Netherlands. Although there are cultural differences between the two subgroups of patients, the groups in this study were too small to be presented separately. Besides the cultural differences between the two subgroups there are also many similarities between the groups regarding their socio economic circumstances and migration history. Persons from Moroccan and Turkish background in The Netherlands who belong to the first generation labour migrants or migrated due to family reunification in many cases received limited education, have a comparable position on the Dutch labour market and live in the more deprived areas of larger cities such as Amsterdam, the capital of The Netherlands, where this study was conducted. The selection of subjects for this study needs to be understood in this perspective. Patients were recruited from the population of patients that applied for rehabilitation treatment at the Institute because of chronic non-specific low back pain. The following inclusion criteria were applied: (1) Origin: (a) born in Turkey or Morocco and at least one parent born in the same country (ethnic minority of the first generation); or (b) born in The Netherlands and both parents born in Turkey or Morocco (ethnic minority of the second generation). (2) Health complaint: chronic low back pain that existed for longer than twelve weeks and that could not be ascribed to specific pathology. The low back is the body region between the lower ribs and the lower buttock fold. (3) Age: Eighteen years or older. (4) Written informed consent.

Patients with chronic low back for which no specific medical diagnosis can be given frequently expect that rehabilitation physicians will give a specific diagnosis of the patients' pain and will offer a medical solution for this pain. In patients with other diseases with a more specific medical diagnosis (e.g. spinal cord injury) discrepancies between physicians and patients regarding their expectations on the content of rehabilitation treatment are less obvious. For that reason a homogeneous study sample, with chronic low back pain patients only, was selected in this study.

Potential participants were identified by surnames of Turkish or Moroccan origin. After their initial request for a first consultation inclusion criteria were checked and patients were asked if they were interested in receiving information about research among patients of non-Dutch origin. If they were, patients were informed by an information letter in their mother language and in Dutch. Subsequently consent was obtained. Rehabilitation physicians that were consulted by twelve patients in the study were informed about this study and asked through verbal communication whether they wanted to participate.

An overview of the participants' characteristics is presented in table 1.

Table 1: Basic profile participants										
Nr.	Sex	Country of birth	Patients' country of birth		Age	Age at arrival	Years of residence in the NL	Language proficiency according to physician	Other household Members	
			Father	Mother					Partner	Children (n)
1	M	2	2	2	24	14	10	Very good	N	0
2	M	2	2	2	45	21	24	Good	Unknown	5
3	M	1	1	1	30	26	4	Poor	W	1
4	M	1	1	1	42	16	26	*	W	2
5	F	2	2	2	37	12	25	Very good	N	2
6	M	2	2	2	33	10	23	Very good	W	1
7	F	2	2	2	27	11	16	*	H	2
8	M	2	2	2	36	24	12	*	W	2
9	M	2	2	2	38	22	16	*	W	3
10	F	2	2	2	39	25	14	*	H	4
11	F	1	1	1	44	17	27	Poor	H	2
12	M	2	2	2	28	22	6	*	W	Unknown

* = These patients have not been discussed with the physician
H=Husband, W=Wife, N=Not applicable, 1=Turkey, 2=Morocco, 3=The Netherlands

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The patients had a mean age of 35 years ranging from 24-45 (SD 6.6). The mean duration of residence in The Netherlands was 17 years ranging from 4-27 (SD 7.7). Eight of the patients were male and four female. Nine of them had a Moroccan background and three had a Turkish background. These patients consulted four different native Dutch rehabilitation physicians. Three of these physicians were interviewed once and one was interviewed three times, as (s)he treated most of the patients with low back pain.

Data collection

Semi-structured interviews were used as method of data gathering. Within three days after the first consultation with the rehabilitation physician the patient was interviewed on the course and content of the consultation. Three patients were interviewed at home. In order to save time the other nine patients preferred to be interviewed at the Institute after they had had their consultation. On average, patient interviews lasted one and a half hour and physician interviews around thirty five minutes. Although the patients were reassured by the interviewer that anything they said was of no consequence to their treatment, only two patients gave their approval to record the interview. Patients feared that recording the interview might be of detriment to how the physician dealt with them. When patients did not allow the interview to be recorded, notes were taken and verified with the patient thoroughly at the end of the interview. All physician interviews were recorded. None of the patients wanted to use a professional interpreter because they or accompanying family members thought themselves proficient enough in their knowledge of the Dutch language. In total, eighteen interviews were conducted, twelve patient interviews and six physicians (3 once; 1 three times) interviews.

An ethnographic interview style was used (10;11). The interviews were open and structured on the basis of a topic list, which was developed with use of a literature study (9). The topic list was regularly evaluated, based on the information revealed by the already administered interviews. The major subjects of the topic list were: patient-provider interaction, explanatory model of the patient and physician on health and illness, the image patient and provider had about each other, prior trajectory (consultation of the general practitioner or specialist), organisational environment, reasons for potential drop-out, demographic information and personal information. The questions in the topic list regarding the patients' explanatory model of their disease were based on the Kleinman interview questions (8;12).

A natural flow of conversation was allowed with a loose sequence of questions. This made it easier for patients to talk about their ideas and experiences. The topics roughly

defined the field that had to be explored (10). The interviews aimed to provide information about feelings, thinking, acting and expressions of the patient (11). The interview questions were open, susceptible to new ideas and easy to understand by the patient. The interviews started with questions that were easy to answer, followed by more difficult or sensitive questions to answer.

Data analysis

From the start of the data gathering onwards, an initial analysis was done to adjust the topics of the interview. This interactive process of data gathering and analysis is typical for ethnographic research (10;13;14). For further analyses of the interview data the verbatim transcription of recorded interviews, notes (taken during the interview) and reflections of the researcher on the interviews were used. On the basis of this information a report was written on each interview.

The reports were analysed making use of the method of constant comparison using following steps: (1) Categorising: The text of the interview reports were categorized into text segments, according to the subjects of the topic list or new important subjects. (2) Coding: Coding was done by labelling text fragments with a code (a keyword), which symbolised the content of the fragment. (3) Comparing: Text fragments that had the same code were compared, to synchronise what each code implied. First, text fragments with the same code contained in one single interview were compared. Second, text fragments with the same code in different interviews involving the same group (i.e. patients or physicians) were compared. Third, text fragments with the same code in different interviews involving different groups (patients or physicians) were compared. (4) Determining: The relation between different ideas was determined by comparing ideas with the existing literature and theoretical conceptions of those ideas (15).

During the process of analysing Atlas-ti was used. Atlas-ti is a software programme to facilitate qualitative analyses of research data. The programme makes it easier to select text fragments, code fragments, make memos on fragments and compare (remarkable) text selections.

Results

In general, the interviewed patients were positive with regard to the consultation session with the rehabilitation physician. They implied that the physician took enough time, listened well, there was extensive debate about the symptoms and additional problems

and the patient was able to say what he wanted to say. However, sources of tension that potentially are associated with future drop-out were found. In the following paragraphs these potential obstacles are highlighted. The quotes used were selected as they were representative for the sources of tension described.

Expectations regarding the aim of treatment

Most patients who consulted a rehabilitation physician had pain for already a number of years. Patients preferably wanted to be cured by the physician and to find a solution to relieve their pain in order to live as normal as possible again. They wished to have more of an insight into the cause of their symptoms as they were afraid that these symptoms would go worse. When the physician informs the patient that no somatic cause of the pain could be identified and that the pain could not be relieved, there exists a situation in which the patient does not know what to do. This is illustrated in the quote below.

PAT-12: "Indeed, the MRI has not had any result and the physician found that the origin of the pain, which now has lasted for two years, can not be explained. That's it! Within half an hour of the consultation session that is what you are told. You have to learn to live with the pain. They can not cure the pain. The proposed treatment therefore aims at distracting your thoughts from the pain. When this is what is told to you, you feel that not enough has been done. Three months you are waiting for a consultation session and within half an hour of that session you hear that there is no hope anymore! You then of course are sad, angry and disappointed. It is true that all kinds of diagnostic examinations are carried out, so you can not say that the physician did not do anything."

All rehabilitation physicians expected that it is not possible to diagnose the cause of chronic pain in many cases. Physicians prescribed diagnostic examinations to be able to exclude a somatic cause. It is important to the physicians to offer some form of pain relief, but the main aim of treatment is to teach patients to cope with their pain. The four interviewed physicians had the idea that patients of non-Dutch origin aim for pain relief more often and stronger than native Dutch patients do.

PHYS-3: "My assumption is, that he will continue to ask for help to relieve the pain and that he will not consider all other factors that come into play. I think that this could be the main obstacle. However, that is exactly the main obstacle that we encounter with the average patient of Dutch origin too."

In conclusion, the interviews with patients and physicians show that the wish of pain relief potentially is an obstacle in rehabilitation treatment. Patients of Turkish and

Moroccan origin as well as native Dutch patients aim for pain relief. However, physicians have the impression that patients of Turkish and Moroccan origin aim for pain relief more often or stronger than native Dutch patients do.

Symptom presentation

The subject of symptom presentation is mainly a problem from the point of view of the physicians. According to the four physicians, patients of Turkish and Moroccan origin reported rather explicitly about their pain. The physicians imply that these patients exaggerate their condition in the hope for a reduction in pain, as is shown below.

PHYS-4: " They have a more exaggerated symptom presentation, it is presented broader, and they are more focussed on additional physical examination".

Patients did not report anything on the manner they reported their symptoms, but they argued it is important a physician takes their problems and symptoms seriously. The notion that physicians experience patients' symptoms as exaggeration therefore potentially results in distrust on the patient side, resulting in potential future drop-out.

Responsibility for illness and treatment

Responsibility for illness and treatment mainly was discussed by the physicians in this study. Some rehabilitation physicians had the opinion that patients of Turkish and Moroccan origin more frequently emphasised responsibility of the physician with regard to health, illness and treatment, compared with native Dutch patients. Physicians believed that patients of Turkish and Moroccan origin frequently thought that they themselves are not responsible for their illness and that other people have to cure them. Physicians reported that patients expected a medical treatment instead of treatment that aimed for coping with pain. The physician has the medical knowledge and therefore is also responsible for a medical solution. Physicians stated that patients detach themselves from the cause of their illness (externalise the cause), this is illustrated by a statement by one of the physicians:

"What do patients of Turkish and Moroccan origin think about their own responsibilities for illness and treatment?"

PHYS-1: "Speaking from my own experiences, these people pass the responsibility onto the physician and it is very difficult to reverse this. It is difficult to get an idea about the health and illness ideas of patients of non-Dutch origin because many times they pass the responsibility back onto the physician. They say: 'You are the physician and you have to know it. The illness just happened to me and I do not have the

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medical knowledge.' Patients expect the physicians to cure their pain, preferably by giving them an injection or a prescription for oral medication."

In contrast with the physicians a majority of the patients thought responsibility for illness and its treatment is a shared responsibility.

"What do you think about your own responsibility with regard to illness and treatment?"

PAT-6: "I do not think that it is the responsibility of the physician to cure you, not a kind of responsibility that you can pass onto him in the sense that: 'I have told you my problems and you must sort them out. When you can not do anything for me, then I get angry.' I do not think that that is the right answer to your question. I do not think that he *has* to cure you and that it is *his* responsibility. I do think that it is his responsibility to give guidance to you. When the physician is not able to guide you, he has to send you to someone else who perhaps is able to do it. It is not acceptable for the physician to say: 'I am sorry. I can not help you any further, please close the door on your way out.'"

Some patients had the opinion that responsibility means they have to inform the physician about all their symptoms and have to comply as conscientiously as possible with the medical advice provided, otherwise the physician cannot help adequately. This is illustrated by an answer of one of the patients:

"What do you think about your own responsibility with regard to illness and treatment?"

PAT-10: "Some patients do not explain everything to the physician but to other people, for instance when they are not satisfied about the treatment. That is not correct. You can not blame the physician that the treatment is not good when you have not explained everything. You have your own responsibility."

Four out of the twelve patients thought the physician was fully responsible for solving their illness problem. According to one of these patients, the physician has to cure his patient. The patient is insured and the physician is the one who gets money from the patient's insurance company for treating the patient.

Thus, there are clearly tensions between physician and patient about responsibilities for illness and treatment. This is one of the critical issues during the rehabilitation treatment and potentially will lead to drop-out further on in the treatment.

Trust in the rehabilitation physician

Trust in the rehabilitation physician seemed to be an important issue for patients, especially concerning the process of diagnosing the cause of their disease. Patients in this study reported that a physician who does extensive physical examination is to be considered a good physician.

PAT-12: "Dutch physicians are nothing; physical examination in Morocco is more useful. I am not satisfied with the results here. In Morocco the healthcare costs are not insured, the physician sends you where he thinks it is appropriate. That is why you have fewer restrictions concerning referrals. You feel well, because physical examination has been done, you feel that the physician tried hard".

The rehabilitation physician is not always willing or able to meet the wishes of patients concerning extensive physical examinations, due to a different medical opinion about the cause of chronic non-specific low back pain. This potentially will lead to a confrontation of views between physician and patient on the aim of rehabilitation treatment. The distrust involved makes it more difficult to overcome this difference in views, resulting in a potential drop-out.

Credibility with regard to foreign diagnosis

The use of a second opinion in the country of origin can result in friction between patient and physician. When a difference of medical opinions occurs, patients potentially distrust Dutch physicians. One patient had been recommended exercise therapy by his Dutch general practitioner. However, the patient felt that there was no improvement, as the pain was not reduced and the medical cause of the pain still had not been diagnosed. During his holiday in Turkey this Turkish patient went for a second opinion to find the cause of his low back pain. The Turkish physician diagnosed the patients' pain by MRI as a lumbar sacral radiculopathy, but this diagnosis was neglected by the Dutch general practitioner. The patient did not understand this, as is illustrated by the quote below.

PAT-3: 'I wonder why the general practitioner did not recommend a MRI to check the diagnosis, if he doubted the expertise of the Turkish physician. When he doubted the expertise of the Turkish physician he could have let the MRI be re-examined by a Dutch physician'.

As a result of the different views on the cause of the low back pain the patient doubted which of the physicians to believe. When a patient has a lack of confidence in his physician this potentially results in future drop-out.

Communication

As soon as the proficiency of the Dutch language is insufficient, the physician can not talk things over in depth and feels that his expertise can not be used adequately. As a result the quality of the consultation is of an unsatisfactory standard.

PHYS-3: "There are always more people coming along with the patient. In general other people are interfering with your consultation session (family members, acquaintances, etc.). After your question often a discussion will start between the patient and his accompanies that will last for a minute or five. Then, after such a long discussion, you are only answered with 'yes' or 'no'. You still did not get your information and still do not know anything. This is making your examination more difficult and shorter. You tend to skip things. You often get a less detailed idea about what exactly is the problem".

When a patient does not understand the physician very well, this problem will not always become clear to the physician. Many patients did not like to admit that they are not proficient in the Dutch language.

"Do you then ask for an explanation?"

PAT-9: "Yes, but not everything.... I myself do not like to say that I do not understand what is said... I feel a bit ashamed to say: "Sorry, I do not understand you". However, under other circumstances then I say: Yes, I do not understand you, Sir'."

Although patients now and then were not able to master the Dutch language and the mutual understanding between patient and physician was disturbed, the Institute has no regulations about the use of professional interpreters. Due to the absence of interpreters at some of the consultations language problems could continue. Patients solved the language problem by having themselves accompanied by their spouse, children or family members. Some of those relatives did not master the Dutch language sufficiently what caused a continuation of the language problems. Furthermore, the help of children accompanying patients can be the cause that personal and sensitive subjects are not discussed.

Two patients mentioned that a certain amount of shame or embarrassment might influence the way patients with a Moroccan or Turkish background ask the physician for help. The quotes below illustrate that some people sometimes are influenced by feelings of shame, which may hinder them receiving adequate care.

PAT-10: "Patients have to mention clearly what kind of symptoms they have, although that is not always done. Sometimes a person with problems concerning urinating might be so ashamed that he does not mention his symptoms to the physician. Fear to mention symptoms influences the treatment negatively. Before the physician knows what is wrong, a lot of time might have been passed away".

PAT-6 "Most people of non-Dutch origin of the first generation, at least in my family, when they do not understand something, they are ashamed a little bit to ask something a second or a third time. This happens less with the second generation. When I would not understand something I would ask directly; what do you mean by that? Or explain it to me I do not know exactly what it means. But they are afraid, the first generation, that people say; don't you know that?!"

When patients due to embarrassment or shame are hindered to fully open up to their physician misunderstanding and confusion potentially will be a result. The underlying questions of the patient might not be treated, possibly resulting in disappointment and an eventual drop-out.

Discussion

Factors that lead to tension in the physician consultations were: differences in expectations regarding the aim of treatment, differences in symptom presentation, different views on responsibilities of patient and physician with regard to treatment, lack of trust in the rehabilitation physician, contradicting views of physicians from patients' country of origin with regard to the cause and treatment of pain, and communication problems. Clearly, there is tension between the perspective of patients of Turkish and Moroccan origin and physicians regarding treatment.

Different opinions of patients and physicians regarding the aim of treatment are clearly based on a contradiction between two different views. Most patients wanted the cause of their non specific low back pain to be diagnosed and wanted medical treatment in order to cure their pain. This wish did not coincide with possibilities of the physicians. According to the physicians, patients with chronic low back pain for which there is no medical cause can't be medically treated in a technical sense and the aim of treatment is not to relieve pain. The physicians' point of view is that chronic non-specific low back pain is a result of an interaction between biomedical, psychological and social factors (16). Rehabilitation treatment of chronic low back pain aims to improve the health related quality of life of patients by learning them to cope with their pain and its consequences

in order to restore their daily functioning. The rehabilitation programme is based on physical training and behavioural cognitive training (17). Due to the fact that the rehabilitation programme at the Institute does not aim to diagnose the cause of the chronic low back pain, patients have to change their explanatory model on the solution of their pain symptoms to benefit sufficiently from rehabilitation treatment. This study showed that patients of Turkish and Moroccan origin, seen through the eyes of physicians, had difficulties to change their view on the treatment of chronic low back pain. Tension between patients and physicians due to a different view on the aim treatment is encountered with native patients too (18). Physicians in this study admitted this source of tension certainly is not specific for patients of non-Dutch origin. Physicians were of the opinion that expectations on pain relief as the aim of treatment possibly are stronger in patients of Turkish and Moroccan origin. Patients who are not able, or have difficulties to change their view on rehabilitation treatment, potentially drop out more often than patients who are able to change their view, because their explanatory model on the origin and treatment of the pain does not match the model of physicians.

Physicians had difficulties to understand the reason why patients of Turkish and Moroccan origin focus more explicitly than native Dutch patients on their pain symptoms. Physicians appeared to interpret explicit presentation of pain as exaggeration of the patients' symptoms. An explanation for a more explicit symptom presentation appears to be that patients who are not able to fully express the severity of their symptoms, due to limited language proficiency, emphasise their pain symptoms more explicitly (19). Interpretation of this more explicit presentation of symptoms as a cultural difference therefore could result in inappropriate treatment (20;21).

Responsibility for illness and treatment was frequently a point of tension between physicians and native patients and patients of non-Dutch origin (22). Physicians reported that patients of Turkish and Moroccan origin more frequently think that they are not responsible themselves for the development of their illness and that other people have to cure them. More responsibility of patients regarding their treatment is a relatively recent subject in the interaction between physicians and native Dutch patients. Through education and easily accessible medical information by television and internet a process of proto-professionalism has taken place (23). Proto-professionalism is the process whereby patients gain more information on causes and treatment of diseases and develop a view on cause and treatment of symptoms. Patients are more able to make individual choices and pass less responsibility regarding the cure of the disease onto the physician. By this process of proto-professionalism, patients' explanatory model

regarding the origin and treatment of pain increasingly matches the explanatory model of the physicians (23). This process of proto-professionalism, which took years for native Dutch patients to develop, appears to be developing differently or more slowly in patients of non-Dutch origin, which is potentially influenced by a lack of proficiency in Dutch. Physicians who expect the same amount responsibility of patients with a different proto-professionalism seem to underestimate the length of the process of proto-professionalism what has shaped the explanatory model of native Dutch patients.

Trust in the physician has been an important source of tension among patients. Many patients with chronic low back pain who applied for rehabilitation treatment often had had a long trajectory of physician and therapists' consultations and hoped that eventually a cure for their pain would be possible. However, due to the fact that many of them have been disappointed more than once, trust in the healthcare system has reduced. This study suggested that contradicting medical information as result of a second opinion in the patients' country of origin limited confidence in the rehabilitation physician even more. In order to prevent tension and friction with patients and to show commitment with the patient, it could be worthwhile for Dutch physicians to seriously re-examine the symptoms of the patient before stating that they need to learn to live with it.

It is alarming that something as simple as language still is a source of tension in the treatment (22;23). This study showed that use of interpreters by physicians is still limited. Communication difficulties between physicians and patients of non-Dutch origin are clearly a source of tension between patients and physicians. Communication between patients and physicians is complex (24). Communication between patients and physicians, who differ in mother language and in ways to express themselves, therefore, appears to be even more difficult.

Some patients in this study reported feelings of embarrassment or shame that could have influenced communication with the physician. Patients feel ashamed for their limited language proficiency and their inability to express their symptoms and questions for help in full.

The factors found are a result of the interaction between patients of Turkish and Moroccan origin and native Dutch physicians. Each separate source of tension is related to the patient-, provider or system level, or a combination of them. Tension related to different views regarding the aim of treatment and communication problems occurred at patient and provider level. Furthermore, tension related to symptom presentation and

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tension related to views on responsibilities of patient and physician with regard to treatment were mainly experienced by the physicians at the provider level. The tension regarding trust mainly occurred at the patient level. Tension regarding communication was, besides the patient and the provider level, also related to the system level, due to missing guidelines on interpreters.

Recent publications underscore the necessity for adequate healthcare for patients of non-Dutch origin in The Netherlands (9;22;23;25). The sources of tension found in this current study appear to be a point of departure for changes or adjustments of the rehabilitation treatment. Some of the sources of tension in treatment occurred due to differences between physicians and patients regarding their explanatory model on the origin and the treatment of pain. In order to reduce these tensions, physicians could match care more precisely to the level of proto-professionalism of the patient, in order to keep them enrolled in treatment. Furthermore, more time for repeated explanation of information in treatment increases the chance patients will include this information in their explanatory model. For physicians this demands more time and patience.

Strengths and limitations of the study

Strength of this study is that interviews were held directly after the first consultation with the physician. Consequently, the opinions of patients were not yet distorted by other factors. An interview further on in the treatment could have been influenced by the interaction between physicians and patients. A disadvantage of this procedure is the uncertainty whether these sources of tension will really lead to drop-out. Therefore, a future study should clarify whether these sources of tension indeed are associated with drop-out of patients.

A saturation point (more interviews would only produce a repetition of the same experiences)(26) in the data collection was not achieved due to practical limitations. In addition, despite careful methodological consideration to enhance the validity and reliability of the study, bias is possible. Issues that may have affected the data collection and data analyses are the personal characteristics of the researcher such as gender (male), background (native Dutch) and personality. Interviews were held in Dutch as the researcher was unable to speak Turkish, Moroccan or Berber. Patients did not want an interpreter to be present during the interview. The non-use of an interpreter potentially led to loss of information provided by patients.

Conclusion

This study showed that there is tension during the first consultation with the rehabilitation physician in patients of Turkish and Moroccan origin due to: differences in expectations regarding the aim of treatment, differences in symptom presentation, different views on responsibilities of patient and physician with regard to rehabilitation treatment, lack of trust in the rehabilitation physician, contradicting views of physicians from patients' country of origin with regard to the cause and treatment of pain, and communication problems. These factors potentially are associated with future drop-out. Future research should clarify whether these factors are indeed associated with drop-out.

Acknowledgements

This study was financed by ZonMw, the Dutch organization for Health Research and Development. Grant number 14350041.

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