

**CHINESE IMMIGRANT WOMEN'S PERSPECTIVES ON COMMUNICATION  
STRATEGIES OF HEALTHCARE PROVIDERS DURING GYNECOLOGICAL  
EXAMINATIONS**

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## **Abstract**

Effective and appropriate communication is a key component of positive clinical experience, while immigrant women's experiences during intimate medical encounters remain underexplored. This thesis explores how Chinese immigrant women perceive, interpret, and engage in communication with healthcare providers during gynecological examinations in Canada. Drawing on Communication Accommodation Theory and patient-centred communication, the study investigates how patients' emotional experiences, sense of agency, and perceptions of care quality are influenced by the communication strategies encountered. Using a qualitative research design, in-depth semi-structured interviews were conducted with twelve Chinese immigrant women who lived in Canada. Data were analyzed following Braun and Clarke's (2006) six-step thematic approach. The results were presented in three major themes: Communication Accommodation Strategies in Addressing Language Barriers; Patient-centred Communication in Alleviating Stress; and Cultural Beliefs Shaping Perceptions of Gynecological Care. Findings indicate that communication during gynecological examinations was co-constructed through healthcare providers' strategies, patients' cultural backgrounds, and patients' active agency. Participants valued provider-initiated accommodations and patient-centred practices, such as linguistic adjustment, anticipatory explanations, privacy protection, and emotional reassurance, which helped reduce anxiety and foster trust. Importantly, patients were not passive recipients of care but actively prepared for and navigated examinations through information-seeking, familiarisation with medical terminology, and in-encounter questioning. Patient agency emerged as a significant theme shaping how communication strategies were interpreted and negotiated by participants. While cultural beliefs related to sexuality and hierarchy influenced expectations, their impact varied by length of residence, education, and health literacy, highlighting communication as a dynamic and relational process

rather than a unidirectional provider-led intervention. This thesis contributes to scholarship on healthcare communication by foregrounding immigrant women's voices in gynecological care and demonstrating how accommodation and patient-centred practices intersect in intimate clinical contexts. The findings offer practical implications for improving communication training and promoting more humane, respectful, and empowering care for diverse patient populations.

**Keywords:** Immigrant Healthcare Experience, Patient-centred Communication, Communication Accomodation Theory

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## **1. Introduction**

In Canada, healthcare interactions involve individuals from diverse cultural backgrounds, leading to inevitable intercultural communication between healthcare providers and patients. Recent immigrants to Canada encounter unique challenges when navigating the healthcare system, impeding their access to necessary healthcare services. Among all health services immigrants may encounter, gynecological examinations stand out for immigrant women as they are critical tools to detect the early stage of cervical cancer and other reproductive issues, and immigrant women are more likely to be underscreened for cervical cancer compared to Canadian-born women (Bacal et al., 2019; Benjamin et al., 2023; Ferdous et al., 2018). Bacal et al. (2019) found that, after adjusting factors like age, income, and education, immigrant women still had higher cervical cancer underscreening rates (30.4%) compared to Canadian-born women (19.0%) and a 32% higher risk of being unscreened, based on data from 17,852 women in the 2012 Canadian Community Health Survey.

Immigrant women of Asian descent, particularly Chinese and South Asian women, are among the most under-screened groups for cervical cancer (Hulme et al., 2016). Xiong (2010) found that Asian immigrant women in Canada had screening rates of just 52%, significantly lower than the 72% of non-immigrant women, based on data from 64,604 women in the Canadian Community Health Survey of that year. As of the 2021 Census, over 1.7 million people of Chinese origin lived in Canada, with 71.6% born outside the country (Statistics Canada, 2024). In 2022, 31,841 Chinese immigrants were admitted, accounting for 7% of total admissions of immigration that year (Immigration, Refugees and Citizenship Canada, 2023).

Given the low screening rates and increasing Chinese immigrant population, it is crucial to investigate the reasons behind this health disparity.

The existing literature mainly focuses on factors influencing screening behaviors and cultural barriers to gynecological examinations, consistently identifying key factors such as age, socioeconomic status, knowledge of the Canadian health system, language, healthcare provider gender, and social stigma around reproductive organs (Bacal et al., 2019; Benjamin et al., 2023; Ferdous et al., 2018; Hulme et al., 2016; Lee-Lin et al., 2007; Ma et al., 2013; Ozturk et al., 2024; Redwood-Campbell et al., 2011; Seo et al., 2018). Many of these studies also highlight the important role of healthcare providers in encouraging participation (Prowse et al., 2024). In O'Connor et al.'s (2014) research on the motivators for women to attend cervical screening, the participants consistently report that providers' attitudes, direct verbal prompting, and trust and ongoing relationships with their providers, can strongly motivate attendance. Echoing this finding, Ferdous et al. (2018) found that providers are both a key source of information and a source of dissatisfaction when they fail to adequately explain procedures to patients or display a rushed, uncaring attitude, which makes patients feel belittled. This was further supported by Hulme et al. (2016), whose interviews with Chinese and South Asian immigrants revealed similar feelings of being rushed or unheard during gynecological screenings. It points to the need to take provider-patient communication into consideration when examining Chinese immigrant women's gynecological examination experiences in Canada.

However, few studies have explored the interpersonal communication between healthcare providers and Chinese immigrant women during gynecological examinations, particularly how different communication strategies impact their experiences. While culture is acknowledged as significant in influencing doctor-patient communication, including variations in communication

styles, health beliefs, values, and language proficiency (Schouten & Meeuwesen, 2005), its application in gynecological settings with Chinese immigrant women remains underexamined. More specifically, this study explores how Chinese immigrant women perceive healthcare providers' communication strategies in gynecological care, how they evaluate the appropriateness and effectiveness of these strategies, and which specific communication characteristics they value. For instance, in Ferdous et al.'s (2018) research, its scoping review indicated that immigrant women appreciated culturally sensitive and linguistically appropriate communication styles regarding cervical cancer screening, while such communication strategies haven't been explicitly outlined. Similarly, a qualitative study of first-generation Chinese immigrant women in the U.S. found that fear, vulnerability, and cultural barriers obstructed their interactions with healthcare providers during cervical cancer screening and recommended culturally appropriate and empathetic communication to promote screening (Seo et al., 2018); however, how such communication should be constituted of and operated for this population remains unclear.

Therefore, this study aims to explore the communication dynamics between healthcare providers and Chinese immigrant women during gynecological examinations in Canada, with particular attention to the cultural factors shaping these interactions. Specifically, the study examines how Chinese immigrant women perceive the reassurance and accommodation strategies commonly employed by healthcare providers, and whether these strategies are experienced as effective or appropriately tailored to their needs. This analysis is informed by the frameworks of patient-centred communication and Communication Accommodation Theory.

In addition, the study examines Chinese immigrant women's unique experiences of negotiating their culturally informed health beliefs and expectations within the Canadian medical

context. It explores how participants adjust to, reinterpret, or resist differing biomedical norms encountered during gynecological examinations. By examining the interplay among patient-centred communication, Communication Accommodation Theory, and participants' perceptions of cultural competence, this study explores how Chinese immigrant women experience and evaluate healthcare communication in Canada. Finally, the findings provide practical insights for healthcare institutions and policymakers by identifying communication practices that facilitate or hinder effective engagement with this population, as well as highlighting gaps in current healthcare communication approaches that affect Chinese immigrant women's access to, and experiences of, gynecological care in Canada.

This thesis is organized into six chapters. In the chapter on Problematization, I reviewed existing literature on the communication strategies used by healthcare providers during gynecological examinations and summarize the major characteristics of these strategies, as well as Chinese cultural beliefs that have been identified in the existing literature as influencing gynecological examinations for Chinese immigrant women. I then presented the theoretical framework guiding the research design, interview guide development, and data analysis, which includes Communication Accommodation Theory, patient-centred communication, and cultural competence in healthcare. The Methodology chapter examines the research philosophy, adopting an interpretivist stance, and presents and justifies the research design. The Results chapter presents the findings under three major themes: Communication Accommodation Strategies in Addressing Language Barriers; Patient-centred Communication in Alleviating Stress; and Cultural Beliefs Shaping Perceptions of Gynecological Care. The Discussion chapter explores these themes in depth in relation to existing literature and theoretical concepts and discusses both

academic and practical implications for future research and policy. Finally, the Conclusion outlines the study's limitations and suggests directions for future research.

## **2. Problematization**

### **2.1 Literature Review**

There is a substantial amount of research regarding women's experiences of gynecological examinations, and women often describe negative experiences of feeling embarrassed, anxious, irritable and uncomfortable (Chang et al., 2013; Ferdous et al., 2018; Hulme et al., 2016; Niziurski, 2016; O'Laughlin et al., 2021; Redwood-Campbell et al., 2011; Seo et al., 2018; Tancman et al., 2022; Yanikkerem et al., 2009). This sense of discomfort and vulnerability, often derived from the exposure of private body parts, makes certain gynecological procedures particularly distressing. This highlights the need for healthcare professionals to approach these procedures with sensitivity to help minimize patients' anxiety and discomfort.

For Chinese immigrant women, navigating the stress and embarrassment related to gynecological examinations is particularly challenging due to additional barriers such as cultural taboos surrounding sexuality and language difficulties (Ferdous et al., 2018; Ji et al., 2010; Ozturk et al., 2024; Seo et al., 2018). These factors can intensify feelings of vulnerability and reluctance to communicate concerns during medical encounters. To address these challenges, healthcare providers can actively implement strategies that reassure patients, acknowledge both emotional and physical discomfort, and create a safe, supportive environment (Gultekin et al., 2025; Niziurski, 2016; O'Laughlin et al., 2021). Furthermore, providers should remain culturally competent by recognizing and adapting to potential cultural barriers that may affect

communication and trust when interacting with patients from Chinese immigrant backgrounds (Lu & Racine, 2015). Failure to address these emotional concerns may lead not only to unsatisfactory experiences but also to the avoidance of future care (Hilden et al., 2003; O’Laughlin et al., 2021; Tancman et al., 2022), which can cause long-term consequences for women’s gynecological health.

### **2.1.1 Communication in Gynecological Examinations**

Interpersonal communication between healthcare providers and patients is one of the major measures that healthcare providers take to help understand patients’ feeling, alleviate patients’ potential stress, and create a positive experience for women in general during a gynecological examination (Huber et al., 2009; Tancman et al., 2022). However, the phenomenon of physicians’ predominant reliance on instrumental language, focusing more on the exchange of medical information rather than patients’ psychological needs, was observed in Dulmen’s (1999) study of gynecologist-patient communication. An analysis of 303 consecutive videotaped consultations involving 21 gynecologists revealed that affective communication addressing patients’ emotional needs occurred far less frequently. But, also suggested in Dulmen’s research (1999), as familiarity between gynecologists and patients increased, such as during follow-up visits, both parties engaged in significantly more social communication. It’s supported by Holroyd et al.’s findings (2001) that women value of familiarity with the healthcare providers, explaining that trust and prior knowledge of the healthcare provider helped to alleviate feelings of pain and vulnerability.

Numerous studies show that healthcare providers’ empathic and patient-centred communication strategies help women in general, not only immigrant women, to better comply with the examinations (Christen et al., 2008; Cook, 2011; Huber et al., 2009; Janssen & Lagro-

Janssen, 2012; Littell et al., 2019; Niziurski, 2016; Dulmen, 1999). The quality of provider-patient communication has been identified as the most critical component of the gynecological examination in Tancman et al.'s (2022) study, which conducted a large cross-sectional survey of over 6,500 women in Israel about their experiences, demonstrating a strong association with overall perceptions of care quality. Similarly, Christen et al. (2008), based on an analysis of 196 videotaped patient consultations conducted at the University Hospital of Basel, concluded that patient-centredness in communication was the key factor influencing patient satisfaction and compliance. However, the majority of research has focused on specific communication strategies employed by healthcare providers, with relatively little attention given to patients' reflections on these interactions. For example, Huber et al. (2009) observed that practitioners commonly employed strategies such as verbal reassurance, inquiries about anxiety or pain, and the suggestion of distractions to help patients cope with the examinations, and considered these strategies useful, while not confirmed from the perspectives of patients. Beyond verbal communication, non-verbal behaviors also significantly influence patient perceptions, for instance, maintaining eye contact rather than focusing on a computer while taking a patient history has been reported to convey respect and enhance the overall experience (Baker & Watson, 2015). Collectively, these studies suggest that effective communication strategies in gynecological care requires an integrated approach that combines verbal reassurance with attentive non-verbal behaviors. However, these findings are mainly based on practitioners' self-reports rather than patients' experiences, with few research on how patients interpret and respond to these behaviors. It points to a broader limitation in the literature: while provider perspectives dominate, patient's voices, particularly from immigrant women, are less visible.

In Skär et al.'s (2020) study, several key principles were identified for fostering trustful communication with patients during gynecological examinations: recognizing women's vulnerability, using personalized communication, and treating women with dignity. These practices can be conceptualized as accommodative behaviors, which, as Baker and Watson (2015) suggest, promote more effective interaction through strategies such as explanation, active listening, and perspective-taking. Drawing on Communication Accommodation Theory and the Willingness-to-Communicate model, Baker and Watson (2015) argue that when healthcare providers, even unintentionally, use nonaccommodative communication strategies with their patients, they are often perceived by patients as impolite, unfriendly, and lacking communicative competence. Conversely, the use of accommodative strategies not only helps care for patients' sense of vulnerability but also enhances their willingness to engage in medical dialogue, thereby contributing to more effective clinical encounters.

#### **2.1.1.1 Recognize Women's Vulnerability**

Skär et al. (2020) drew on the narratives of gynecological teaching women, a group of women who were specifically trained to instruct medical students in the pelvic examination process and who consented to be examined as part of the training, to identify factors perceived as essential for women to develop a trustful patient-professional relationship during pelvic examinations. A central theme was healthcare providers' awareness of women's vulnerability, with participants emphasizing the importance of creating a safe and comfortable environment. This emphasis on awareness of women's vulnerability aligns with Baker and Watson's (2015) research, which showed that patients complimented and described experiences of accommodative communication with terms like "sympathetic," "reassuring," "caring," and "explained," indicating that when healthcare providers actively listen and address concerns,

patients feel more comfortable. Building on this, communication with attention to women's vulnerability can be implemented through behaviors such as asking about comfort levels and preferences, for instance, inquiring who should be present during the examinations, and through procedural rituals that safeguard privacy and dignity. Skär et al. (2020) also observed that personal comments about a woman's appearance were suggested by the interviewed gynecological teaching women as inappropriate and detrimental to trust, underscoring the importance of professional boundaries in maintaining a respectful atmosphere. Similarly, O'Laughlin et al. (2021) extend this argument by emphasizing the role of language, recommending that providers avoid terms such as "bed" and "stirrups" in favor of neutral alternatives like "table" and "footrests," thereby promoting greater comfort and respect. Overall, these findings demonstrate that communication practices which acknowledge women's vulnerability, respect their preferences, and with mindful language is central to women's sense of safety and trust during gynecological encounters.

#### **2.1.1.2 Use Personalized Communication**

Personalized communication has been identified as central to women's experiences during gynecological examinations, as it helps enhance patients' self-esteem. Skär et al. (2020) emphasized that effective personalized communication involves using clear, non-technical language, explaining the pelvic examination step by step, and allowing sufficient time for women to ask questions. They emphasized communicating in a language the woman understands, which means not only linguistic accessibility, such as avoiding medical jargon or adapting to the patient's language proficiency but also tailored explanations to the woman's level of knowledge, emotional state, and immediate concerns. Participants further stressed the importance of providing feedback, responding directly to women's questions and reflections, and pacing

information appropriately, particularly given that women may feel overwhelmed when receiving complex information before or during the examination. A similar pattern was observed in Chen et al.'s (2008) study, which argued that verbal communication should take place only when patients are fully dressed, as this helps ensure comfort and facilitates open expression.

Supplementing this emphasis on providing information at appropriate timing, Hillard (2025) also stressed the importance of obtaining informed consent before the start of gynecological practice, letting patients receive comprehensive information not only regarding the rationale for the recommended procedure and available management alternatives, but also about the potential for procedure-related pain. Though originally focusing primarily on educating medical students and trainees about pain management and consent during their preclinical training, these recommendations extend beyond the classroom to real-world clinical contexts, where clinicians are suggested to engage patients by inquiring about their existing knowledge and concerns, offering clear explanations of the procedure's indications, benefits, risks, and alternatives, and addressing potential misinformation. Such practices not only signal care but also foster a sense of partnership between patient and clinician.

Skär et al. (2020) emphasized that women valued receiving information when healthcare professionals ensured that procedures were clearly explained and understood in advance, including outlining each step of the examination and allowing sufficient time for women to ask questions. Supporting this point, a large-scale survey of 6,058 women in Israel revealed that communication and privacy were among the most highly valued aspects of the gynecological encounter. Specifically, over 97% of respondents of the study rated receiving explanations before and during the examination, being warned in advance of painful procedures, and having opportunities for questions afterward as important or very important (Tancman et al., 2022). This

strong preference for anticipatory communication reinforces Skär et al.'s (2020) findings that emphasized communication should be appropriately timed. Cook (2011) supported these findings and added further nuance by showing that, despite clinicians' use of video-screen technology to provide real-time explanations, such as displaying on a television screen and explaining what providers observed during the examination, participants largely perceived these communication strategies as ineffective. Patients reported that explanations offered during the procedure did little to reduce anxiety nor enhance understanding, underscoring the importance of carefully considering not only what is communicated but also when and how it is delivered.

Respond meaningfully to patients' concerns to improve women's gynecological examination experience is particularly important for Chinese immigrant women whose first language is not English. For these women, the clarity and accessibility of language become central to their care experience (Hislop et al., 2003; Li et al., 2021; Lee-Lin et al., 2007; Redwood-Campbell et al., 2011). The adaptation of communication styles, through simplifying terminology, clarifying explanations, and ensuring comprehensibility (Ahmed et al., 2017), not only facilitates information exchange but also reduces anxiety of patients, particularly those facing linguistic barriers. Such responsiveness to language needs therefore represents a critical dimension of personalized communication, improving both emotional comfort and perceived quality of care. Together, these findings illustrate that communication must be strategically adapted to individual needs and contextual factors to maximize comfort and understanding.

### **2.1.1.3 Treat Women with Dignity**

Treating women with dignity during gynecological care involves addressing their concerns and expectations with respect and at the same time educating them about their bodies (Skär et al., 2020). Wijma & Siwe (2004) draws on Freire's Pedagogy of the Oppressed to frame

communication in gynecological examinations as a potential process of empowerment, beginning with an awareness of unequal power dynamics between physicians and patients. From this perspective, enhancing women's knowledge about their bodies and the examination process is not merely a matter of reducing anxiety, but a critical step toward redistributing agency within the clinical encounter. By demystifying medical procedures and clarifying their purpose, such practices enable women to feel more at ease, assert a sense of control, and participate actively in decision-making. This conceptual understanding is supported by many empirical results. For instance, Ashtarian et al. (2017) indicated that empowering women with knowledge about pelvic examinations can help reduce embarrassment and foster a supportive, non-threatening environment for knowledge sharing. Similarly, Bates et al. (2011) outlined specific strategies to promote dignity and comfort, such as explaining the procedure step by step, showing the speculum, and demonstrating the function of the instruments. Overall, this perspective is particularly relevant for Chinese immigrant women, who have reported limited sexual health knowledge due to the absence of formal sex education (Chang et al., 2013; Luo et al., 2023).

#### **2.1.1.4 Impact of Gender on Communication**

Another widely discussed issue in gynecological care experience is the gender of healthcare providers. Many studies report that patients, particularly those from ethnic minority groups, often express a preference for female providers during gynecological examinations (Aubrey et al., 2017; Ferdous et al., 2018; Redwood-Campbell et al., 2011; Hulme et al., 2016). Small et al. (2014) found that a strong preference for female obstetricians mainly appear among immigrant, particularly Muslim women. While these self-reported studies typically attribute the gender preference to cultural or religious beliefs, and a general sense of comfort with same-gender providers, they do not probe more deeply into factors beyond culture. That is, while

gender is often highlighted, research suggests that communication style may be the more influential factor in shaping patient experience. Janssen and Lagro-Janssen (2012) conducted a systematic review on the preferences of female patients seeking gynecological or obstetrical care, focusing on the impact of physician gender on patient satisfaction and communication style. They concluded that most patients preferred female gynecologist-obstetricians, partly due to their more patient-centered communication style. This finding is supported by Christen et al. (2008), who argued that female gynecologist-obstetricians tended to adopt more patient-centered communication, characterized by attentiveness, greater information-sharing, and higher empathy. However, despite findings on gender differences in communication style, the researchers also questioned the tendency to essentialize communication behaviors based on gender. For example, the study by Dulmen and Bensing (2000), which analyzed videotaped encounters with 107 female and 196 male physicians, provided meaningful insights but cannot conclusively establish gender as the determining factor in communication style. Contextual elements, such as medical training, institutional norms, and cultural expectations, may also shape how providers communicate.

Though with these limitations, the conclusion drawn by Janssen and Lagro-Janssen (2012) that patient satisfaction is strongly related to a patient-centered communication style and to physicians' ability to understand patients' problems from an integrated perspective remains a robust insight. Therefore, the research on how genders of healthcare providers impact patients' gynecological examination experience further reinforce that empathic and patient-centered communication, rather than providers' genders, is essential for enhancing patients' comfort and compliance during the gynecological examinations.

#### **2.1.1.5 Importance of Healthcare Provider's Active Inquiry**

Healthcare providers' understanding of patients' experiences during gynecological examinations often depends heavily on their observation and interpretation of patients' reactions. In their study, Huber et al. (2009) identified four common responses among patients who experienced discomfort or refused to continue an examination: crying, screaming, pulling away, and verbal expressions of pain. These findings suggest that while verbal communication often serves as the primary cue for clinicians to recognize distress, nonverbal signals, though subtle, are equally critical indicators of discomfort. However, relying solely on observable or verbalized reactions places the burden of communication on the patient and overlooks the social and psychological barriers that may inhibit women from expressing pain or refusal openly. For instance, Tancman et al. (2022) found that only 43.4% of the participants reported they would notify the gynecologist if they experienced physical discomfort or pain. However, the study did not examine why women were reluctant to speak up, nor did it consider whether similar patterns occur in other contexts. In this context, active inquiry, which stands for the clinician's proactive effort to ask about and attend to signs of discomfort, becomes essential. The study by Dulmen (1999) suggested that certain conditions can encourage patients to speak up; specifically, patients who received clear and comprehensible information about their treatment were more likely to initiate psychosocial questions. This finding emphasized that patient communication is not merely a matter of willingness but is shaped by how healthcare providers frame and facilitate the interaction. Both studies highlight the need for clinicians to actively motivate patients to express discomfort or concerns in order to enhance their examination experience.

Building on the discussion of patients' reluctance to express discomfort and the need for proactive inquiry by clinicians, research among Chinese women further illustrates how cultural and relational dynamics shape communication during gynecological examinations. In Yang's

(2024) study involving 14 in-depth interviews with women in China, participants reported consciously restraining themselves from expressing discomfort in order to avoid provoking dissatisfaction or disapproval from healthcare providers. However, some participants mentioned they would cautiously voice their demands before and during the examinations to negotiate with the healthcare providers to make the examination process more bearable for themselves, in an overall indirect way. These findings highlight that women's willingness to communicate discomfort or pain is mediated not only by personal comfort levels but also by perceived power hierarchies and cultural expectations within clinical encounters. Therefore, in the context of gynecological examinations, patient-centered communication should actively take women's cultural beliefs and backgrounds into account to create a setting where they feel safe, respected, and empowered to express discomfort or concerns.

Furthermore, to capture more indirect or nonverbal cues from the patients, one potential approach, as suggested by Cook (2014), is for nurses and other providers to take responsibility for recognizing signs of distress even when patients do not explicitly express them. In this way, the patient-centred communication can help ensure that patients feel supported, ultimately enhancing the quality of care during intimate medical procedures. To conclude, these findings demonstrate that patient-centered, sensitive, and culturally-aware communication is essential for ensuring women feel comfortable, respected, and engaged during gynecological examinations.

### **2.1.2 Chinese Cultural Beliefs**

Existing research indicates that Chinese immigrant women encounter unique challenges in gynecological care settings, many of which are shaped by their cultural backgrounds (Ferdous et al., 2018; Hulme et al., 2016; Lu & Racine, 2015; Redwood-Campbell et al., 2011; Seo et al.,

2018; Xiong, 2010). While prior studies have predominantly emphasized cultural barriers that discourage participation in cervical cancer screening, such as sexuality-related stigma, language difficulties, and hierarchical doctor-patient dynamics, far fewer have examined how cultural influences shape communication during the gynecological examination itself. Findings on barriers to participation provide important insights; however, it is also essential to acknowledge that women who have already undergone examinations may display different communication patterns, having navigated or overcome certain cultural obstacles. Overall, these cultural considerations remain significant to shaping patient experiences and should inform a more nuanced understanding of the experience of gynecological examinations of Chinese immigrant women in Canada.

#### **2.1.2.1 Sexuality-related Stigma**

Holroyd et al. (2001) demonstrated that the gynecological examination was not regarded by Chinese women as a neutral medical practice but was instead deeply intersected with cultural understandings of sexuality and propriety. In their study on Hong Kong Chinese women's experiences and perceptions of the pap smear, participants often framed the procedure in relation to their sexual relationships, with some reproducing victim-blaming narratives by suggesting that the virus resulted from having multiple sexual partners. The researchers also quoted Mo (1993), who noted the Cantonese slang expression "ham soup" or "salty and wet," a derogatory term used to label women perceived as sexually inappropriate. This linguistic association underscores the negative cultural connotations attached to women's sexual activity, which in turn inhibited open discussions of sexual health and contributed to women's reluctance to undergo Pap smears. The connotation that undergoing a pap test is related to sexually badness is also reflected in the research by Seo et al. (2018). In their research, 12 women aged 34 to 64 living in Los Angeles,

California, were interviewed on personal experiences, perceptions, and barriers related to cervical cancer screening, and they convergently mentioned one factor that being taught from a young age to keep “feminine problems” private, as discussing them could lead to social judgment and stigma, with others potentially believing they “did something bad or wrong.” It reflected the deep-embedded cultural taboo surrounding the discussion of gynecological health, therefore contributing to the modesty they hold which impede them from participating in the examinations.

And the cultural taboo is especially prominent towards the unmarried Chinese women population, as cultural beliefs in Chinese society that link these diseases to sex and marriage, often viewing them as “illegitimate” for unmarried women, gynecological diseases were overwhelmingly associated with sex, reproduction, and marriage, regardless of the actual cause of the disease. This led to negative and stereotypical labels for patients. They were often perceived as promiscuous, unclean, lacking self-respect, or irresponsible (Dong, 2023). Therefore, gynecological examinations were seen not just as a health issue, but as a symbol of moral failure or a problematic lifestyle, resonating with Holroyd et al.’s (2001) conclusion that pap tests are far from culturally neutral medical procedures.

The sense of modesty is exacerbated by the sexuality-related stigma, leading the Chinese immigrant women to feel the sense of vulnerability, embarrassment, and a loss of autonomy during the examination (Holroyd et al., 2001; Seo et al., 2018), indicating that modesty in this context goes beyond personal shyness, reflecting a culturally embedded negotiation of sexuality, gender roles, and social stigma surrounding gynecological care. Participants in Holroyd et al.’s (2001) research described the experience as have the “most secret place disclosed in front of a third person,” making them feel powerlessness and fear of criticism. Participants in Seo et al.’s

(2018) research also indicated the sense of vulnerability as feeling “like a piece of meat on the butcher table,” highlighting the dehumanizing and passive experience they felt.

To address culturally rooted modesty and feelings of embarrassment, both healthcare providers and patients adopt various coping and communication strategies. From the perspective of healthcare providers, doctors in Taiwan, especially the male doctors, navigate the cultural taboos by making the exam less personal and less sexually charged (Chen et al., 2008). Chen et al. (2008) observed that providers often employ communication strategies to depersonalize the procedure, such as psychologically distancing both themselves and their patients from the intimate nature of the exam, minimizing verbal interaction during the examination, and postponing explanations until the patient is fully dressed and back in the consultation room. While such strategies are designed to reduce embarrassment, they may inadvertently conflict with patients’ expectations of patient-centred communication. For example, Seo et al. (2018) found that Chinese immigrant women in Los Angeles frequently attributed their feelings of vulnerability to a lack of communication and explanation from providers, while many described the Pap smear as something to be passively endured rather than a procedure in which they could actively participate.

From the perspective of patients, they are not merely passive recipients of these dynamics but display agency in resisting stigma. By analyzing 792 online posts and conducting 14 in-depth interviews with Chinese women, Yang (2024) documents how some Chinese women actively reframe gynecological examinations as routine health checks, mentally separating the practice from cultural associations of shame. However, Yang (2024) also acknowledges that the active redefinition is more common among educated, urban women, suggesting that socioeconomic position mediates women’s capacity to negotiate cultural stigma. Such findings point to the need

for a more complex understanding of both provider strategies and patient agency, recognizing that communication during gynecological care is shaped not only by cultural taboos but also by intersecting factors such as class, education, and urban-rural background.

The formation of these cultural beliefs, beyond the cultural inheritance, is related to the vacancy in health education related to sex. In Redwood-Campbell et al.'s (2011) research, the interviewees said that Chinese women are reserved when talking about sexual health and not discuss sexual health openly when unmarried. Similarly, according to Dong (2023), through in-depth interviews with 26 unmarried women recruited from Chinese social media "Douban," parents, reported as primary gatekeepers of these expectations, seldom provide sex education, leaving young Chinese women with significant gaps in knowledge. At the same time, participants reported that prior to diagnosis, most of the information they had encountered came from media portrayals resembling "sex fantasies," which offered little meaningful education about sexual health risks. The degree of impact of the lack of sex education varied according to age and educational background, but the overall lack of accurate information created an environment where silence and misinformation shaped Chinese women's expectations of gynecological health. Accompanied with the health education vacancy is the lack of knowledge of risk factors. Holroyd et al. (2004), in their study of socio-cultural influences on Chinese women's cervical screening practices in Hong Kong, found through interviews with both patients and physicians that many older women did not view themselves as at risk due to reduced sexual activity. Similarly, Lee-Lin et al. (2007) emphasized the need for more education among Chinese American women regarding gynecological risk factors as a way to increase cervical cancer screening rates. While much of the literature links insufficient health education directly to lower screening uptake, its impact extends further into the clinical communication itself. A lack of

knowledge surrounding reproductive health may not only discourage screening but also constrain Chinese immigrant women's ability to communicate efficiently with healthcare providers during gynecological examinations, thereby limiting opportunities for effective patient-centered care.

### **2.1.2.2 Doctor-patient Dynamic**

In general, there's an inherent power imbalance between healthcare providers and patients, with the former being the "help providers" and the latter the "health seekers" (Baker & Watson, 2015). In the Chinese culture, the doctor-patient relationship appears to be more hierarchical due to the culturally embedded respect towards authority, in this case, the healthcare providers. Research suggests that this power imbalance can be addressed through patient-centred care strategies, which seek to redistribute power by involving patients in decision-making and reinforcing their sense of control over their bodies and treatment. However, how Chinese immigrant women perceive and adopt these patient-centred strategies still requires further exploration.

Pun et al. (2018) examined the doctor-patient dynamic in five East Asian regions, including Mainland China, Hong Kong, Japan, South Korea, and Taiwan to understand how the different cultures in these areas influence these communications and how doctor-patient communications contrast with those in Western countries. By conducting a comprehensive review of 38 studies published between 2000 and 2017 on how doctors and nurses communicate with patients, Pun et al. (2018) found that Asian cultures place greater emphasis on an egalitarian ethos rather than individualism, and on Confucianism rather than Christianity. As a result, values such as harmony, obedience, and respect for elders are often prioritized, contributing to sustaining paternalistic and asymmetrical models of doctor-patient relationships in East Asia. Liu et al. (2025) also found that in high power distance cultures such as China, doctor-patient

relationships are more likely to be perceived as hierarchical, with physicians occupying an authoritative role and patients expected to comply rather than actively participate. Drawing on Hofstede's cultural framework, the researchers provide robust cross-cultural evidence comparing patients' experience in China and the UK, showing that Chinese patients reported significantly lower communication quality, reduced participation in decision-making, and more restrained emotional expression. These patterns were strongly predicted by higher power distance and stronger collectivist orientations, indicating that patients in such contexts may normalize and tolerate more directive, less interactive communication styles (Liu et al., 2025). Similarly, according to Wang (2010), compared with patients in the United States, Chinese patients tended to express greater satisfaction with doctors who adopted a dominant communication style, suggesting that the respect of the authority was not only accepted but, at times, expected. Similarly, Ahmed et al. (2017), who conducted a systematic review and thematic synthesis of the communication barriers that exist between physicians and immigrant patients, further indicate that the cultures in which doctors are seen as authority figures will make patients unlikely to speak freely unless prompted, which provided a hint for the healthcare providers to more proactively motivate patients to express. However, these interpretations risk oversimplifying patients as passive recipients of care. More recent developments indicate a shift in China, where patients are showing a growing preference for greater participation in medical decision-making (as cited in Pun et al., 2018).

Some Chinese patients' views of healthcare providers have also evolved in an opposite direction. In contemporary China, the doctor-patient relationship is often associated with mistrust or even conflict, which may contradict the traditionally held perception of a hierarchical relationship. With market economics, in some patients' eyes, doctors are seen as servants,

merchants, or even greedy liars (Cao & Wei, 2014). This is supported by Yang et al.'s (2019) study, which found that Han Chinese, the majority ethnic group in China, were more likely to perceive their relationship with physicians as transactional in nature. This shift complicates essentialist explanations of asymmetry based solely on culture, raising critical questions about how evolving ideologies of medical authority may influence doctor–patient interactions in immigration contexts. In settings such as Canada, where these culture-related expectations of healthcare providers from the perspective of Chinese immigrant patients remain underexplored, it is important to take rising patient awareness, globalization, and changing expectations of medical professionalism into consideration.

Furthermore, gender significantly shapes the doctor-patient dynamic for Chinese women. Pun et al. (2018) argue that the communication barriers become particularly pronounced in sensitive contexts, for example, when female patients consult male urologists in Hong Kong or during discussions of sexual health in Korea, where the patriarchal norms further exacerbate communication barriers. Siu (2015) also observed that women often perceived interactions with male physicians through the lens of existing gender hierarchies, regarding it as natural to defer to male authority in the same way they would to their husbands at home. The dynamic led to passive acceptance of treatment decisions, even when women felt dissatisfied, as communication largely flowed one-way from doctor to patient. Similar patterns were discussed in Seo et al.'s (2018) interviews with first-generation Chinese American immigrant women in Los Angeles, where participants reported the lack of understanding of the purpose of Pap or HPV tests and were hesitant to seek clarification from their busy physicians. While they expressed strong trust in medical authority, often deferring to doctors' judgments with statements such as "I did whatever tests my doctor thinks I should do," the trust was largely passive, reflecting a

communication gap rather than informed engagement. Such a pattern left little space for negotiation or shared decision-making, thereby undermining women's autonomy over their bodies and healthcare.

Though much of the existing research tends to construct Chinese women as passive recipients of care, Yang (2024) challenged this narrative through an analysis of 792 online posts and 14 in-depth interviews with women in China, demonstrated that women are not merely passive victims; instead, they adopt a spectrum of strategies to navigate pain and embarrassment, including compliance with medical authority to cautious negotiation and, at times, direct resistance. They also use euphemisms to describe their sexual history, aiming to make the examination process more bearable and to manage providers' potential judgments. While these practices illustrate women's agency, they remain embedded within cultural frameworks that prioritize deference to authority, suggesting that Chinese women's navigation of the gynecological healthcare is best understood as a negotiation between constraint and agency rather than a simple story of passivity.

Overall, existing research has examined the hierarchical relationship between healthcare providers and patients in China, highlighting patient subordination to medical authority, which often leads to avoidance of questions and limited communication, which is further intensified in cross-gender clinical encounters. Although studies have shown that cultural influences remain significant for immigrants in countries such as the United States and Canada, much of these works overlooks the evolving nature of cultural beliefs, including shifting perceptions of medical authority and increasing patient agency. Therefore, the influence of cultural values should be examined more carefully in the context of gynecological examinations among Chinese

immigrant women in Canada, particularly in the light of emerging perspectives on cultural change.

### **2.1.2.3 Language**

Language barriers are a common challenge for immigrant populations when accessing healthcare services. Limited proficiency in the host country's official language can hinder effective communication, increasing the risk of misunderstandings or a complete lack of understanding regarding medical advice, procedures, and treatment plans. According to Ferdous et al.'s (2018) systematic scoping review of barriers to cervical cancer screening faced by immigrant women in Canada, much research agreed that limited fluency in either English or French impedes effective communication and constitutes a major barrier to screening.

Among all language barriers, the use of complex medical terminology is widely recognized as significantly complicating communication for patients during clinical encounters, particularly when it is delivered in a non-native language. Ahmed et al. (2017), in their systematic review and thematic synthesis of physician-immigrant communication, found that such language differences not only limit comprehension but also shape the broader quality of healthcare delivery by reinforcing structural inequities in access and trust. In other words, linguistic gaps compound existing power imbalances in healthcare settings, positioning immigrant patients as less informed and therefore less empowered to question, negotiate, or participate in decisions about their care, thus discouraging them from seeking care and erode trust in physicians. Building on this, Tsai and Ghahari (2023) highlighted the psychological impact of language barriers, noting how they generate frustration and anxiety for immigrant patients, which in turn can further inhibit meaningful engagement with healthcare providers. Together, these findings suggest that language barriers are not isolated communication

challenges but part of a broader cycle in which limited understanding, emotional strain, and structural disadvantages interact to create barriers in gynecological examinations.

In response to the language barriers, physicians often adopt more directive and less interactive communication strategy with immigrant patients, as they may withhold certain information, believing that patients with limited language skills may not fully comprehend it (Ahmed et al., 2017). Though mentioned by Wang (2010) that Chinese may be more acceptable towards the dominant communication style from the healthcare providers, this strategy leads to low participation of the patients and negatively impact shared decision-making. The situation is compounded by Chinese culture of preference for indirect communication and a less active patient role during consultations (Yang, 2024). In Pun et al.'s research (2018), the indirect communication preference is explained from the perspective of high content culture versus low context culture. In high-context cultures, for example, China, communication is more indirect, implicit, and relational, meaning is derived from context, non-verbal cues, and the relationship between speakers. In low-context cultures, for example, U.S., communication is direct, explicit, and task-oriented, where messages are spelled out clearly and precisely. The difference adds an extra layer of complexity to the physician-patient communication, particularly in cross-cultural healthcare encounters. In high-context settings, patients may refrain from asking direct questions or voicing concerns, assuming that physicians will infer their needs from subtle cues or shared understanding. Conversely, physicians trained in low-context traditions may expect patients to articulate their concerns explicitly and may misinterpret silence as agreement or compliance. This cultural mismatch would heighten the risk of miscommunication and generate communication barriers.

Relying heavily on both professional and non-professional interpreters to bridge communication gaps, the cardiac nurses interviewed by Li et al. (2025) describe challenges when communicating with Chinese-speaking patients. Although interpretation effectively helps reduce communication barriers, the nurses still reported several challenges with interpreter services, including limited availability, difficulty in scheduling, and variability in the quality of interpretation. Furthermore, though nurses preferred professional interpreters for their accuracy and confidentiality, they often had to rely on family members or bilingual staff due to resource constraints. Because such procedures are intimate and often leave patients feeling vulnerable, the involvement of an additional, unfamiliar person may be perceived as intrusive, then heightening anxiety and reducing patients' willingness to disclose sensitive information. This dynamic reveals a critical paradox: the mechanism intended to facilitate communication may inadvertently exacerbate discomfort and hinder effective dialogue in highly sensitive healthcare contexts.

Moreover, due to the complex cultural influences, some immigrants express a preference for physicians of similar ethnic backgrounds, assuming they will be more familiar with the cultural beliefs and their native language, and thus able to communicate more effectively (Ahmed et al., 2017). However, such preference risks reinforcing essentialist assumptions that ethnicity alone guarantees effective communication. The effectiveness of doctor-patient communication depends not solely on shared cultural background but also on physicians' ability to engage in culturally sensitive, patient-centered communication. Lu and Racine (2015) argued against the tendency to essentialize Chinese immigrant women's health beliefs and practices by attributing uniform characteristics to the group. Overemphasizing ethnic concordance can lead to stereotyping Chinese health beliefs and practices and obscure structural barriers, such as limited

translation services and lack of institutional support for cultural competence (Lu & Racine, 2015). This highlights the need to move beyond cultural matching, toward strategies that promote equity and meaningful dialogue across diverse patient populations.

### **2.1.3 Conclusion**

The existing literature demonstrates that women's experiences of gynecological examinations are profoundly shaped by the quality of communication with healthcare providers, particularly in relation to empathy, patient-centredness, recognition of vulnerability, and respect for dignity. For Chinese immigrant women, these communication dynamics are further complicated by culturally rooted sexuality-related stigma, hierarchical doctor-patient relationships, language barriers, and differing expectations surrounding authority and participation. Prior research has identified a range of communication strategies employed by healthcare providers, such as reassurance, information provision, and interpreter use, and has highlighted their potential benefits in reducing anxiety and improving compliance. However, much of this work privileges providers' perspectives, with comparatively limited attention to how Chinese immigrant women themselves perceive, interpret, and evaluate these communication practices during gynecological examinations.

Addressing these gaps, the present study focuses on Chinese immigrant women's own reflections on healthcare providers' communication strategies during gynecological care. And in the following section, I will explain how theories including Communication Accommodation Theory, patient-centred communication and cultural competence provide a useful conceptual framework for examining how healthcare provider communication is operated, interpreted, and negotiated in gynecological examinations for Chinese immigrant women.

## **2.2 Conceptual Framework**

### **2.2.1 Communication Accommodation Theory**

Communication Accommodation Theory, developed by Howard Giles (2016), explains how individuals adjust their communicative behaviors during interaction. Giles emphasizes that accommodation occurs within an intergroup context: speakers' adjustments are shaped by their interpretations of others' social identities and group affiliations. Communication during gynecological examinations represents a particularly strong intergroup setting, where interaction with health care providers is embedded in marked status and role dynamics, doctor versus patient, helper versus seeker, expert versus layperson. When immigrant identity is added to this context, the salience of intergroup dynamics increases further. Patients from different cultural backgrounds often experience greater language and cultural distance, prompting more frequent or more pronounced adjustments, both by themselves and by providers, to bridge gaps in understanding and comfort.

A core element of Communication Accommodation Theory is its typology of adjustment strategies. People can converge, diverge, or maintain their communicative style relative to others (Dragojevic et al., 2016). Convergence involves making one's communication more similar to the partner's, in the healthcare setting maybe slowing speech, simplifying medical terminology, or softening tone to enhance rapport (Watson, Jones, & Hewett, 2016). Divergence involves accentuating differences to signal distinctiveness or maintain authority, such as increasing the use of technical terms or avoiding patient questions. Maintenance refers to sustaining one's default style without significant adjustment. Objective and subjective accommodation may not align: a physician might believe they are simplifying explanations while a patient perceives the tone as patronizing. Communication Accommodation Theory also distinguishes five accommodative

strategies particularly relevant to health communication (Gallois, Ogay, & Giles, 2005; Watson, Jones, & Hewett, 2016): (1) Approximation refers to linguistic changes such as speech rate, vocabulary, and accent, and in a medical context can help bridge knowledge gaps between provider and patient. (2) Interpretability involves tailoring message complexity to the patient's level of health literacy, a critical factor for informed consent and adherence. (3) Discourse management concerns regulating topics and turn-taking so that patients can ask questions, check understanding, and share their own explanatory models of illness. (4) Interpersonal control addresses the negotiation of roles; for example, whether a physician allows a patient to express disagreement or interrupts to maintain control. (5) Finally, emotional expression refers to conveying reassurance, empathy, and respect, behaviors repeatedly linked to patient satisfaction and reduced anxiety. Watson, Jones, and Hewett (2016) argue that when health professionals apply these strategies, patients report higher satisfaction, better recall of information, and greater adherence to treatment. Conversely, non-accommodation can erode trust and exacerbate feelings of vulnerability. Similarly, Baker and Watson's (2015) qualitative analysis revealed that patients described more accommodative behaviors during positive healthcare experiences, such as doctors listening, asking questions, and explaining information. Conversely, negative experiences involved nonaccommodative behaviors, where patients felt belittled or ignored. These perceptions significantly undermined patients' willingness to communicate symptoms, emotional discomfort, and informational needs during the examination.

Communication Accommodation Theory provides a framework for both designing research and analyzing findings by helping identify which communicative behaviors are perceived as accommodative and how they map onto specific accommodative strategies. For instance, the model can be used to examine how health care providers' language simplification,

use of interpreters, or nonverbal sensitivity influence patients' comfort and understanding. At the same time, Gasiorek (2016) highlights one of Communication Accommodation Theory's limitations: the issue of awareness. To what extent are speakers conscious of the adjustments they make, and to what extent are listeners aware of these adjustments in return? Applying Communication Accommodation Theory in this research helps understand the extent to which the patients sense the healthcare accommodative or non-accommodative communication strategies, and their feelings of being accommodated.

### **2.2.2 Patient-Centred Communication Framework**

The concept of patient-centered communication is widely applied in health communication research, emphasizing that interactions between providers and patients should be respectful, responsive, and collaborative. Epstein and Street (2007, p. 2) describe the strategies of patient-centred communication as “eliciting, understanding, and validating the patient’s perspective; understanding the patient within his or her psychosocial context; reaching a shared understanding of the problem and its treatment; and helping the patient share power through meaningful involvement in decisions about health care.” Building on the Institute of Medicine’s (2001) broader framing of patient-centered care as care that “respects and responds to individual patient preferences, needs, and values,” this approach views communication not just as information exchange but as a dynamic process of relationship-building, empowerment, and healing (Epstein & Street, 2011).

In this study, patient-centered communication is used as an interpretive lens to examine Chinese immigrant women’s accounts of their interactions with healthcare providers during gynecological examinations in Canada. Epstein and Street (2007, p. 67) highlight six functions patient/family-clinician communication, including fostering the doctor-patient relationship,

exchanging information, responding to emotions, managing uncertainty, making decisions, and enabling self-management. This framework directs attention to specific verbal and nonverbal behaviors that shape women's perceptions of being respected, heard, or dismissed. It also focuses on power and empathy in clinical encounters, as well as contextual factors such as language, cultural norms, and institutional practices. This perspective makes it possible to link women's narratives to actionable communication strategies that align gynecological care with their preferences, values, and sense of dignity (Epstein & Street, 2007).

### **2.2.3 Culturally Competent Communication**

Sharing many of the principles of patient-centred communication and aiming to tailor care to individual patients (Lurgain et al., 2024; Saha et al., 2008), cultural competence emphasises the importance of taking the patients' cultural backgrounds into account, to overcome cultural and linguistic barriers in healthcare. Defined as "the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences" (Lisa & Roter, 2003, cited in Beach et al., 2005, p 2), it helps healthcare providers improve the quality of care by acknowledging the social, cultural, and linguistic factors in patient-provider interactions (Chinoporou et al., 2025). In a comprehensive historical and comparative analysis of cultural competence and patient centeredness by Saha et al. (2008), it is suggested that the models used to describe and evaluate cultural competence in healthcare include dimensions of knowledge (e.g., understanding the meaning of culture and its importance to healthcare delivery), attitudes (e.g., having respect for variations in cultural norms) and skills (e.g., eliciting patients' explanatory models of illness). For example, McDonald et al. (2021) applied Schwarz et al.'s (2015) Conceptual Model of Cultural Competence, which identifies five dimensions: cultural awareness and sensitivity; behavior, defined as providers' responses to patient beliefs; patient-centered

communication; practice orientation; and self-assessment, or reflection on provider biases. Similarly, Campinha-Bacote (2002) proposed a model comprising five inseparable components: cultural awareness, the honest examination of one's own biases to avoid imposing them on patients; cultural knowledge, the active acquisition of information about how diseases, treatments, and health beliefs vary across groups; cultural skill, the ability to gather relevant cultural data and conduct accurate examinations of diverse populations; cultural encounters, repeated real-world interactions that challenge assumptions and prevent stereotyping; and cultural desire, the motivation to continue learning and providing care across cultural differences.

The three core dimensions of cultural competence outlined by Saha et al. (2008), knowledge, attitudes, and skills, offer a structured approach for analyzing research findings on patient-provider communication in gynecological settings, focusing on how providers' cultural knowledge (such as understanding the meaning of modesty or gender differences), attitudes (such as respect for variations in cultural practices), and skills (such as tailoring explanations) shape the quality of interaction. This approach also highlights how healthcare providers' levels of cultural competence directly influence patients' perceptions of respect and their comfort during highly intimate medical encounters such as gynecological examinations.

### **2.3 Summary and Argument**

This study draws on three complementary theoretical frameworks, Communication Accommodation Theory, patient-centred communication, and culturally competent communication, to examine how Chinese immigrant women experience communication with healthcare providers during gynecological examinations. Together, these frameworks provide an integrated lens for understanding how communication practices shape women's perceptions of respect, comfort, agency, and engagement in care.

Communication Accommodation Theory (Giles, 2016) offers a framework for analyzing how healthcare providers adjust their language, interactional style, and emotional expression in a clinical context characterized by professional hierarchy and immigrant identity. It directs attention to specific accommodative and non-accommodative strategies, such as simplifying medical terminology, managing conversational turn-taking, negotiating interpersonal control, and expressing empathy, as well as how these strategies are perceived by patients. Patient-centred communication complements this perspective by emphasizing respect for patients' perspectives, responsiveness to emotional needs, and meaningful involvement in decision-making. Culturally competent communication further extends the framework by foregrounding the role of cultural knowledge, attitudes, and skills in shaping provider-patient interactions, particularly in intimate and sensitive clinical encounters such as gynecological examinations.

By integrating these frameworks, the study moves beyond a focus on cultural barriers to healthcare access and instead examines the communication processes through which Chinese immigrant women interpret providers' behaviors and evaluate their care experiences. The framework is used to guide the development of interview questions and to structure the analysis of participants' narratives, with particular attention to how communication strategies are experienced as accommodating, respectful, or dismissive, and how cultural beliefs influence these interpretations.

Therefore, the study addresses the following research questions: How do Chinese immigrant women perceive healthcare providers' communication strategies during gynecological examinations? And under this main question, two sub-questions follow: Which communication practices are experienced as patient-centred or accommodative, and which are perceived as non-

accommodative? How do cultural beliefs and expectations shape women's interpretations of these communication practices?

And in the next section, I present the data collection and analysis methods used to answer these research questions.

### **3. Methodology**

#### **3.1 Research Philosophy**

This study is grounded in interpretivism, which posits that reality is not objective or fixed but is constructed through individuals' lived experiences and interpretations (Crotty, 1998; Schwartz-Shea, 2014). From an ontological perspective, this research recognizes the existence of multiple, context-dependent realities (Alharahsheh & Pius, 2020), as participants' experiences of gynecological examinations are shaped by cultural background, migration experiences, healthcare systems, and interpersonal interactions with healthcare providers. In healthcare settings, particularly during intimate encounters such as gynecological examinations, patients' perceptions of communication, comfort, agency, and stigma cannot be fully understood through objective measurement alone but must be interpreted through participants' own narratives and sense-making processes. Adopting an interpretivist paradigm therefore allows this research to centre participants' subjective experiences and acknowledge the multiplicity of realities embedded in their accounts. Furthermore, consistent with interpretivist assumptions, the researcher is positioned as an active interpretive instrument in the research process (Pervin & Mokhtar, 2022). Complete neutrality is neither assumed nor sought; instead, reflexivity was maintained throughout data collection and analysis to remain attentive to how my perspectives, assumptions, and interactions may shape the research process and interpretation of findings. Throughout data collection and analysis, I critically reflected on how my position, assumptions, and interactional choices might influence participants' responses and the interpretation of findings. Reflexivity was practiced through maintaining reflexive notes during and after interviews and documenting analytic decisions during coding. When being analyzed, the codes and themes were repeatedly compared against raw interview data to ensure they were grounded

in participants' accounts rather than my personal assumptions. This reflexive stance is particularly important given the sensitive nature of the topic and the emphasis on participants' emotional and embodied experiences.

Given the study's aim to explore how Chinese immigrant women perceive and interpret communication, sexuality, and stigma within gynecological care, a qualitative approach was adopted, to understand how participants construct their experiences, how they reflect on them, and how broader cultural and healthcare contexts shape these interpretations. Interviews were selected as the primary method of data collection because they provide a flexible and interactive space for participants to articulate personal, and sometimes sensitive, experiences in their own words (DeJonckheere & Vaughn, 2019). Semi-structured interviews were chosen to balance consistency and flexibility. The interview guide (Appendix A) included key topics of communication barriers, patient-centred communication, cultural influences. It consisted of main open-ended question with followed probing questions. Based on the literature review, subtle power dynamics may exist in communication with healthcare providers during gynecological examinations; participants might not explicitly recognize these dynamics until prompted by specific questions. Additionally, the interview guide facilitated discussion when participants were hesitant to actively disclose or recall their experiences, enabling exploration of their perspectives in an acceptable and comfortable manner. The first section of the interview guide focuses on participants' overall experiences of gynecological examinations and was informed by patient-centred communication literature emphasizing patients' subjective experiences and emotional responses to care. These questions invited participants to narrate their most recent examination, allowing meaningful interactional moments or significant barriers encountered to emerge. The second section addresses experiences of discomfort, informed by literature on vulnerability and

power asymmetries in gynecological care. This section explores how participants perceived and responded to discomfort, including their willingness to express concerns and interpretations of providers' responses. The third section examines language use and communicative understanding, drawing on Communication Accommodation Theory. The questions explored how understanding was negotiated and the strategies both healthcare providers and patients used to facilitate communication. The fourth section focuses on cultural influences on communication, informed by intercultural communication literature on sexuality, modesty, and stigma of Chinese immigrant women's. Questions were framed to avoid presuming cultural effects, allowing participants to define the relevance of culture in their experiences. The final section invites broader reflections on cultural difference and doctor-patient communication, informed by debates in patient-centred and culturally competent communication. This section explores participants' preferences, expectations, and concerns regarding cultural awareness and equitable treatment.

## **3.2 Research Strategy**

### **3.2.1 Sampling Strategy**

The participants consisted of twelve Chinese immigrant women currently living in Canada, each of whom had recently undergone at least one gynecological examination within past three months. Purposive sampling was used (Palinkas et al. 2015), and in this study, to recruit participants with direct and recent experience of gynecological examination, as this was necessary to get detailed, first-hand accounts of communication experience during examinations. Selection criteria ensured participants' ability to reflect on their interactions with healthcare providers and on their communication experiences, thereby ensuring that the data captured rich and contextually grounded perspectives relevant to the study's research questions. Snowball

sampling was also used to ask the participants to voluntarily refer others to participate. At the conclusion of each interview, participants were invited to refer other potential participants who might be eligible and interested in the study. Interested individuals were then contacted directly by the researcher. Recruitment continued until sufficient data was obtained to answer the research questions, thematic saturation was reached (i.e., no substantively new themes emerged from the interviews), and variations and nuanced perspectives within existing themes were sufficiently elaborated.

### **3.2.2 Recruitment Process**

In total, thirteen individuals expressed interest in participating, of whom twelve met the eligibility criteria. Nine participants were recruited via social media and three were referred by participants. The Chinese social media platform Rednote was utilized for participant recruitment, as its user demographic is the Chinese Mandarin community worldwide. To be eligible for the study, participants must: be a Chinese immigrant living in Canada; be aged 18 years old and above; have undergone at least one gynecological examination within the past three months or expect to have one in the next one to three months and be able to schedule an interview shortly after their examination to maintain a clear recollection of the process. These criteria ensured that participants had relevant and recent experiences to reflect on, allowing for more accurate and meaningful insights into their interactions with healthcare providers. After initial contact through social media or direct outreach, emails containing detailed information about the study and participation instructions were sent to the participants' provided email addresses. Once a participant responded affirmatively, a mutually convenient interview time was scheduled, and the informed consent form was sent in advance. Participants were required to review and sign the consent form before the interview commenced.

### **3.2.3 Data Collection**

The interviews were carried out via Zoom to accommodate participants' comfort, schedules, and geographical locations. The interviews were conducted between July and October 2025. All interviews were audio-recorded with participants' consent. Participants were informed again of the topic of the interview and their right to withdraw at any point without consequence at the commencement of each interview. The interview lengths varied from thirty-five to sixty minutes. All interviews were conducted in Mandarin. Participants reported feeling more comfortable speaking in their mother tongue, which allowed them to provide richer and more detailed responses. I am fluent in Mandarin and shared a similar cultural background with participants, which facilitated rapport-building and reduced potential language barriers during the interviews. Notes were taken immediately after each interview to document contextual details, initial analytic impressions, and reflexive observations.

### **3.2.4 Data Analysis Methods**

I followed Braun and Clarke's (2006) thematic approach, which consists of six steps: familiarising with the content, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. The data analysis was both deductive and inductive. After familiarising myself with the raw data, I developed a coding framework based on Communication Accommodation Theory, patient-centered communication principles and culturally competent communication. According to Gallois, Ogay, and Giles (2005) and Watson, Jones, and Hewett (2016), Communication Accommodation Theory categorizes communicative behaviors into five perspectives: convergence, approximation and interpretability, discourse management, interpersonal control, and emotional expression. Patient-centered communication strategies were coded according to their functional roles, including

relationship building, information exchange, responding to emotions, and shared decision-making (Epstein & Street, 2011). Finally, I used codes to capture the participants' perspectives on cultural competence, that is, healthcare providers' communicative adjustments based on variations in cultural knowledge, attitudes, and skills (Saha et al., 2008). In addition to themes anticipated from the literature, several unanticipated but salient themes emerged inductively from the data. These included participants' strategic self-education prior to appointments to compensate for perceived communication gaps, flexible negotiation of gender preference based on professional trust rather than cultural norms, and participants' active resistance to being culturally stereotyped by healthcare providers. These themes highlight practical, experience-based insights into how participants navigated communication during gynecological examinations.

Although the interviews were conducted and transcribed in Mandarin, initial coding was carried out in English to ensure consistency with the final report. Following the coding process, selected quotations were translated into English for inclusion in the report.

### **3.2.5 Ethical Considerations**

There was a possibility that the interview may trigger negative memories related to previous gynecological examination experience, and as the topic is culturally and emotionally sensitive within the target community, the participants may feel uncomfortable disclosing some details. To address the potential harms, the researcher paid special attention to potential distress and ensured that participants feel comfortable throughout the process, and state that the participants would be able to withdraw from the interview at any time without any consequences when they feel uncomfortable. Pseudonyms were used in all transcripts, and this paper to ensure that participants cannot be personally identified. Any identifying information, such as job titles,

organization names, or specific personal characteristics, were not asked, and removed or modified if mentioned to protect privacy. Video-recordings of the interviews were used for transcription purposes only and were deleted as soon as the transcriptions are complete. The researcher also provided to all participants, as part of the consent form, the list of mental health supports and general health information resources that was compiled by the Government of Canada for different provinces and territories: <https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html>. This study was approved by the Research Ethics Board of University of Ottawa, and the approval form is in the Appendix B.

The AI tools of ChatGPT and DeepL were used to support translation and language clarity of quotes only but was not used for data analysis, coding, or interpretation. They were both used to translate selected interview excerpts from Chinese into English, with the instruction of “translate the quotes into English, maintaining the original meaning, level of complexity, and the speaker’s tone.” All translated quotations were subsequently reviewed and revised by the researcher to ensure accuracy and fidelity to participants’ intended meanings. When using the tools, I turned off the platform setting that allows content to be used to train and improve the model to protect participant confidentiality. No personally identifiable information was entered into any AI tools, and all data handling complied with ethical and privacy considerations.

#### 4. Results

Table 1 presents the sociodemographic characteristics of the participants. The sample included twelve Chinese immigrant women ranging in age from their 20s to over 50 years old, with most participants aged between 30 and 39. Length of residence in Canada varied from less than five years to over ten years. Regarding examination experience, the majority of participants had undergone internal pelvic-related examinations, including Pap tests (n = 10) and IUD-related procedures (n = 2), while some participants also reported experiences with external examinations such as CT scans (n = 2) and ultrasound scans (n = 1); overlap existed across examination types. All participants had completed their most recent examination within three months prior to the interview. In terms of education, most participants held a master's degree (n = 8), followed by doctoral degrees (n = 2) and bachelor's degrees (n = 2). One participant holds a medical degree and has prior experience practicing Western medicine in China. Her dual perspective as both a former healthcare provider and a patient offers a more comprehensive, rather than exclusionary, lens, allowing her to demonstrate an informed understanding of provider practices while also articulating her own experiences and perceptions as a patient.

**Table 1**

*Demographic Information of Participants*

<b>Characteristics</b>	<b>Category</b>	<b>Number</b>
<b>Age Range</b>	20 - 29	3
	30 - 39	6
	40 - 49	2
	50+	1
<b>Years in Canada</b>	< 5 years	5
	5 - 10 years	3
	10 - 15 years	3
	> 10 years	1
<b>Type of Exam (Overlap)</b>	Pap Test	10
	IUD	2

	CT scan	2
	Ultrasound	1
<b>Education</b>	Bachelor	2
	Master	8
	Doctor of Philosophy	2
<b>Experience of Gynecological Exams</b>	First-time	3
	Not first time	9

Three major themes emerged from the semi-structured interviews, with sub-themes emerged grouped under the three domains:

- Communication Accommodation Strategies in Addressing Language Barriers
- Patient-centered Communication in Alleviating Stress
- Cultural Beliefs Shaping Perceptions of Gynecological Care

Each major theme comprised multiple subthemes, and patient agency was reflected across all three themes, positioning it as a salient cross-cutting dimension that effectively functioned as a fourth overarching theme. Taken together, these themes provide a nuanced account of how Chinese immigrant women perceive and engage in communication with healthcare providers during gynecological examinations, as examined through the combined perspectives of Communication Accommodation Theory and patient-centred communication. For confidentiality, participants are identified by letters A-L in the quotes below. Table 2 provides an overview of the themes and subthemes identified during the analysis.

**Table 2**

*Overview of Themes and Subthemes*

<b>Theme</b>	<b>Subtheme</b>	<b>Description</b>
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<b>Communication Accommodation Strategies in Addressing Language Barriers</b>	Communication Accommodation Strategies Used	Healthcare providers accommodated participants' language needs by proactively checking comprehension, asking clarifying questions, simplifying medical jargon, using Mandarin when appropriate, and responding to patients' own questions or initiatives.
	Challenges in Communication Accommodation Implementation	Participants noted that these communication strategies were not always effective, as understanding and engagement could still be limited despite providers' efforts.
	Patients' Efforts to Converge	Participants actively managed potential language challenges by seeking Mandarin-speaking doctors and conducting online research before clinic visits.
<b>Patient-centered Communication in Alleviating Stress</b>	Privacy and Respect for Bodily Autonomy	Participants experienced their privacy as being respected through clear explanations, consent at each step, and transparent communication about the presence and role of a chaperone, which enhanced their sense of autonomy and humanized the examination process.
	Clear, Step-by-Step Communication	Participants experienced and appreciated clear, step-by-step explanations and real-time updates during gynecological examinations as reducing anxiety, increasing predictability, and enhancing their sense of control.
	Responsiveness and Emotional Reassurance	Participants valued healthcare providers' attentiveness to verbal and non-verbal cues, frequent check-ins, and empathetic reassurance as practices that reduced anxiety, conveyed human warmth, and made them feel treated as a person rather than a medical case.
	Relational and Personalized Communication	Participants perceived relational and personalized communication, such as appropriate small talk, empathy, humor, and adaptation to personal background, as fostering trust, reducing anxiety, and humanizing gynecological examinations, though some participant initially felt culturally unfamiliar or uncomfortable with these strategies.
	Divergent Perceptions and Patient-Initiated Strategies	Participants showed divergent perceptions of patient-centred reassurance, with some viewing it as ineffective for managing anxiety while others actively used humor and small talk to ease tension.

<b>Cultural Beliefs Shaping Perceptions of Gynecological Care</b>	Sexuality, Modesty, and Stigma	Participants acknowledged that cultural conservatism and limited sexual-health education shaped initial embarrassment, modesty, and hesitation in gynecological communication, but most reported actively moving beyond these influences over time through increased health knowledge, adaptation to Canadian medical norms, proactive self-expression, and flexible balancing of gender preference, language needs, and professional trust.
	Perception of Hierarchy and Doctor-Patient Relationship	Participants expressed varied attitudes toward medical hierarchy, ranging from passive trust and compliance with doctors' authority to more egalitarian views that emphasize collaboration, personal autonomy, and indirect negotiation rather than uniform deference, challenging the assumption of a fixed hierarchical doctor-patient relationship among Chinese immigrant women.
	Cultural and Ethnic Matching	Some participants preferred healthcare providers with shared or similar linguistic and cultural backgrounds, as it reduced communication barriers, encouraged greater information sharing and provider engagement, and enhanced patients' comfort and participation, even when exact cultural or national backgrounds did not fully align.

In the following sections, I will present the results of the thematic analysis

#### **4.1 Communication Accommodation Strategies in Addressing Language Barriers**

Language barrier emerged as a significant challenge during the gynecological examination. The participants consistently indicated that, despite having sufficient daily communication capability in English, medical jargon, including names of symptoms, organs, and medical instruments, still was a major source of communication barriers. The participants perceived their healthcare providers to be able to successfully recognize these language-related barriers and employ a range of communication accommodation strategies to facilitate the conversations. These strategies included: checking the patient's language capability, using simpler terms, explaining or paraphrasing medical jargon, speaking at a slower pace, and, when possible, switching to the patient's mother tongue when appropriate. The participants also noted

that these practices were used flexibly in response to situational needs. This theme addresses the research question by detailing how language-related barriers are managed through healthcare providers' accommodative communication strategies, informed by Communication Accommodation Theory, alongside participants' perceptions of their partial effectiveness and patients' adjustment of their communication styles.

#### **4.1.1 Communication Accommodation Strategies**

The participants described two main ways in which their healthcare providers became aware of patients' limited understanding of the conversation: through providers' proactive checks of patient's comprehension, and through patients' own initiation of questions and requests for clarification. In the first case, it depends on the healthcare provider's subjective observation and judgment of patients' reactions. **Participant C** recalled that during her CT scan, the technician explained the procedure and then checked whether the instructions were clear:

He explained that there would be instructions asking me to breathe in and out, and that I just needed to follow them. Then he checked if I could understand him, as he said some people might not, and I told him I could.

Besides the routine checks, there were also situations where the healthcare providers noticed the nonverbal behaviors of the patient showing confusion and adjust communication accordingly. As **participant L** said:

During the procedure, I sometimes wasn't sure what (the doctor) wanted me to do, like how to position my legs or what exactly she meant. But she noticed that I seemed a bit confused, and she would rephrase what she said and explain it in another way.

However, the precise interpretation of patients' levels of comprehension can be quite challenging; the more frequent situation is that the healthcare providers proceeded with routine conversations until the patient expressed confusion and raised the concern. In these situations, patients' verbalized uncertainty prompted providers to adjust their communication and take

responsibility for making the information understandable for the patients. For example,

**participant B** recollected her initial conversation with the doctor who performed a pap test:

She told me she was going to do a Pap smear, and I asked what that was. Then she explained that it's a screening test for cervical cancer and gave me a simple, plain-language explanation instead of using technical terminology.

A similar experience was reported by **participant H**, who recalled that the doctor initially mentioned the test without explanation:

The doctor asked me if I had ever had a gynecological exam, and I said no. Actually, she didn't mention what a Pap test was at first. I asked her what it was; she explained a bit, but I didn't really understand. Then she asked again whether I had ever had one.

Across interviews, these interactions reflected a common accommodation strategy in which healthcare providers reformulated their explanations in response to patients' questions.

Participants noted that providers often replaced medical terminology with simpler or more everyday language:

When I want to express something, or when (the healthcare providers) want to explain something, they would try to put it in words that are easier to understand, using simpler or more everyday terms. (**Participant E**)

This participant also reported that she was unsure about the names of the instruments in English, and she chose to openly express her concern. After knowing the names of instruments in English would be a barrier for the patients, the healthcare provider adjusted her choice of words by saying "I'm about to insert this 'thing'" rather than specific names of medical instruments.

Three participants described situations in which their healthcare providers switched from English to Mandarin when both parties shared the same language to cater to the patient's language choice. While some language-related challenges remained, such as the matching issue of the English and Chinese names of medications, the participants indicated that the switch of

language helps them reduce the communication challenge and increase the level of convenience, making their experience almost like seeing a doctor back in their home country.

One good thing about my family doctor is that he speaks Chinese. Being able to communicate in Chinese really reduces a lot of communication difficulties for me, especially during medical consultations where there are so many technical terms that I'm not familiar with. For example, when I explain my medical history in China or ask questions about my treatment, I can do so in Chinese, and he understands me perfectly.  
**(Participant J)**

#### **4.1.2 Challenges in Communication Accommodation Implementation**

Participants generally reported that these communication accommodation strategies helped reduce language-related difficulties during the gynecological examinations and diagnosis. Most patients expressed satisfaction with the strategies, describing them as “good,” “friendly,” “comforting,” and even being “grateful” for them, as they felt cared for in an intimate examination, as well as in the process of navigating an unfamiliar medical system as non-native English speakers. However, participants also emphasized that these communication strategies did not always work. In several cases, participants reported that simplified explanations remained difficult for them to understand, and they needed to guess based on context to interpret healthcare providers' meaning. Some participants attributed this to limited familiarity with medical terminology, indicating that such terms were harder to remember and were not always clearly linked to recognizable symptoms. In this case, the participants reflected that they might often require further research to fully overcome this obstacle. For instance, **participant H** said:

There were still some terms they mentioned that I didn't fully understand (after provider's explanation). I was somewhat guessing or partly guessing and partly inferring. I might need to recall later what they had just mentioned, whether it might mean this, or perhaps it sounded like this pronunciation, and then I would check to see what it actually means.

In addition, several participants mentioned the use of translation tools as a way to overcome the language obstacles. The use of translation tools often followed a period of mutual

negotiation between the healthcare providers and the patients, rather than being introduced directly. **Participant J** described the use of the translation tool as useful and efficient, demonstrating a positive attitude toward this approach: “If there were some more difficult words, the family doctor would use a translator in real time to explain the meaning of the term. It’s quite efficient.” By contrast, **participant H** described a situation in which no translation tool was used, despite her continued difficulty understanding certain terms. The participant expressed understanding and agreement with this approach, explaining that she believed it would be inappropriate for healthcare providers to use a translator without the patient’s active request and consent. She explained:

If it’s the patient who finds a translator, or the doctor finds an official interpreter, that’s fine. But if the doctor suggests using a translator right away, it feels impolite. The doctor is assuming the patient’s confusion is simply due to language (rather than knowledge), without even asking if they need one. It assumes too much, like assuming translation alone will solve the problem.

These perspectives reflect variations in participants’ expectations regarding translation support and the participants’ sensitivity to the implicit assumptions that healthcare providers may make about patients with different cultural and linguistic backgrounds. It also highlights the importance of distinguishing between language barriers and health literacy challenges. In this sense, the participant’s reflection suggests that effective communication requires not only linguistic accommodation but also an awareness of patients’ varying levels of medical understanding and preferences regarding translation supports.

#### **4.1.3 Patients’ Efforts to Converge**

In addition to the communication accommodation strategies used by healthcare providers, the participants also reported that they proactively managed the potential language challenges by themselves. Some participants intentionally adjusted their behaviors to align with their healthcare

providers, reflecting patterns defined as convergence in Communication Accommodation Theory. The specific strategies reported by participants included: seeking same-language healthcare providers, conducting online pre-visit research, and disclosing language limitations to request communication accommodation.

Two participants acknowledged that they intentionally seek Mandarin-speaking family doctors to avoid potential inconvenience caused by the language barrier from the origin.

However, the participants also admitted that the option of a same-language family doctor can be quite limited and competitive, which means they would sacrifice some other factors. For instance, **participant K** described the experience of prioritizing language-matching when choosing a family doctor:

My family doctor is from Taiwan, and he speaks Chinese. When I was choosing the family doctor, my primary requirement was to find a Chinese-speaking doctor to solve the communication problem, gender didn't matter (that much). But the clinic is really far; it takes two or three hours each time I go.

Beyond adjusting their choice of healthcare providers, participants frequently mentioned conducting online research before the clinic visits. Their preparation aimed to familiarise themselves with the examination procedures, learn how to describe their symptoms and requests in English more authentically and concisely, and study the medical jargons they expected to encounter. Seven out of twelve participants reported that they engaged in such pre-clinic research to prepare not only for communicating in a non-native language, but also for building psychological readiness through increased medical knowledge.

When researching, three participants mentioned using AI-based tools. For example, **participant D** described her experience of preparing the oral description of her symptoms by using AI:

I started with ChatGPT. I told it what kind of situation I was experiencing, and it helped me with that. For example, it might suggest, 'Is this how you want to describe your condition to the doctor?' I found the expressions it gives quite natural and conversational, which makes them very convenient to use. I think ChatGPT is actually more accurate than some translation apps.

**Participant J** reported a similar experience, noting that pre-visit research using ChatGPT helped her form expectations about possible outcomes:

Before seeing the doctor, I asked ChatGPT how I should deal with this issue. ChatGPT gave me some suggestions, so I already had a certain expectation in mind. When the doctor later told me that no treatment was needed, I felt that it made sense: it was more or less what I had anticipated.

These accounts show the emerging role of AI as an informal preparatory and interpretive function in healthcare communication. For these participants, ChatGPT functioned not merely as a translation tool but as a means of preparation and expectation management, reducing anxiety and enhancing confidence during clinical interactions.

Finally, participants also talked about how they actively sought language accommodations during consultations. One participant described how she took the initiative to disclose her identity as an immigrant and a non-native English speaker to her healthcare provider:

I proactively mentioned that I didn't grow up in North America, so the doctor explained more to me. She told me that Pap tests are very common in Canada and that many women my age have to wait a long time for appointments. I felt she was trying to make me feel more at ease, especially because she was worried that I might not be very familiar with the process. (**Participant L**)

This demonstrated her optimistic mindset toward overcoming language barriers and her proactive attitude in encouraging providers to adjust their communication strategies, such as avoiding jargon and using simpler phrases, to align with her level of English proficiency and enhance her overall examination experience.

#### **4.1.4 Summary**

To summarize, language barriers during gynecological examinations still exist for the participants in the form of difficulties with medical jargon and unfamiliar clinical procedures, even with good English proficiencies. Participants perceived healthcare providers as actively recognizing these challenges and employing flexible communication accommodation strategies, such as simplifying terminology, checking comprehension, rephrasing explanations, adjusting speech pace, and, when possible, switching to the patient's mother tongue, to facilitate understanding. At the same time, participants emphasized that the effectiveness of these strategies varied and often required patients' own initiative and adaptive efforts.

These accommodative practices also reflect key principles of patient-centred communication, as providers' responsiveness to patients' linguistic needs, preferences, and expressed uncertainties helped foster reassurance, respect, and a more collaborative interaction during an intimate clinical encounter. Next, in the section 4.2, the theme of application and effect of patient-centred communication will be discussed in more detail.

#### **4.2 Effectiveness of Patient-Centered Strategies to Alleviate Stress**

Participants described a range of patient-centered strategies employed during gynecological examinations, through both verbal and non-verbal forms of communication. These strategies primarily served to safeguard patients' privacy, provide clear information, offer reassurance, and ultimately build a trustful doctor-patient relationship. Patient-centered communication practices were organized into four sub-categories: privacy and respect for bodily autonomy; clear, step-by-step communication; active monitoring and responsiveness; emotional reassurance and empathy; and relational and personalized communication. This theme answers

the research question by exploring different patient-centred communication strategies that participants recalled their healthcare providers used and how they felt about them; the participants appreciated the characteristics of patient-centred communication but still were unsure whether they could fully address their discomfort and stress during the consultation.

#### **4.2.1 Privacy and Respect for Bodily Autonomy**

Participants consistently reported that their privacy was respected through a series of actions by healthcare providers that maintained their dignity, personal space, and sense of control in the examination process. First of all, they talked about environmental and procedural safety measures. Before and during the examinations, participants were kept in private and secure spaces, with doors closed, curtains drawn, and blankets provided to cover their bodies, so they felt protected in situations where exposure was necessary. **Participant K** specifically praised the use of paper cover gown to maintain privacy and compared her gynecological examination experience with those before in China:

In China, privacy wasn't emphasized, and exams could feel awkward. Here, doctors are much more attentive to privacy. They provide a disposable paper gown worn like a dress, covering the whole body and exposing only the area being examined. Compared to my experiences in China, this feels much more respectful.

Participants also highlighted communication practices that contributed to their sense of privacy being respected. Women who underwent Pap tests described being given clear instructions before the examinations about how to prepare for the procedure, including guidance on how to undress and use available coverings for comfort and modesty. **Participant I** recalled that her healthcare provider offered detailed explanations about the facilities and procedures, specifying how to use the curtain and examination pad, and what personal items, such as shoes, could be kept on: "The provider explained each detail carefully: what to remove, what I could

keep on, and that a pad would be provided if needed. I felt my privacy was well protected.” Furthermore, several participants noted that healthcare providers would step out of the room while participants prepared to undress, reinforcing a sense of autonomy and safety. The participants also noted that the healthcare providers would check their personal information and gain consent before the examination procedure.

Another way participants felt their privacy and dignity were respected was through communication emphasizing humanization, making them feel treated as human. Several participants described anticipating the gynecological examination with anxiety, shaped by previous experiences or exposure to online media narratives portraying gynecological examination procedures as painful and dehumanizing. These narratives led the participants to expect to have negative and painful experience:

Before having this examination, I often saw posts on Rednote where people in China described cervical cancer screening as a very frightening experience. Because of that, I already had some psychological expectations and thought the procedure might be quite painful. **(Participant B)**

Entering the examination with these preconceptions, participants reported feeling unexpectedly valued when they encountered patient-centered communication strategies during the examinations, which challenged and altered their prior assumptions. For instance, **participant B** reflected on her previous experiences in China as a point of comparison, noting:

Doctors in China are usually very busy, seeing a large number of patients every day. Here, however, the examinations are based on an appointment system, and I feel that doctors here have more time to explain things and care more about the patient’s experience. Still, I didn’t expect the doctor to explain everything in such detail. I felt genuinely happy about that, and I felt respected.

Another practice frequently mentioned by participants was the explicit discussion of chaperone presence, i.e. the involvement of a support staff member or another individual who accompanies the patient during gynecological examinations. Participants described varying

circumstances regarding chaperones, which generally fell into two categories: situations in which the participant proactively requested a chaperone, and those in which the healthcare provider insisted on having one present. In both situations, participants reported that their privacy and dignity were respected. They described feeling that their privacy was neither violated when a chaperone was present, nor overlooked in cases where no explicit request of chaperone was made. For instance, **participant B** described how her proactive request to have her husband accompany her was followed by the healthcare provider's careful verbal confirmation. The provider restated potential privacy concerns that might cause discomfort, ensuring that the participant was fully informed and retained control over the situation:

I asked the doctor whether my husband could accompany me during the examination. She said it was possible, but she also expressed her concerns regarding privacy. She explained that since the cervical cancer screening involves removing clothes and being almost completely undressed, she wanted to confirm whether I was comfortable with my husband being present. I told her I had no problem with it. That made me feel very comfortable, because she truly respected my personal choice. It wasn't that my privacy was dismissed just because it was my husband accompanying me; she still made sure my privacy and comfort were protected.

In the other scenario, healthcare providers primarily suggested the presence of a chaperone because the provider was male, of a different gender from the patient. Some participants also observed posters on the examination room walls indicating that a female nurse or another appropriate member must be present whenever a male healthcare provider attends to a female patient. Participants reported that providers' explicit communication of this policy made them feel respected and safe. **Participant F** described how her male family doctor routinely addressed this issue during Pap tests: "Because my family doctor is male, whenever he performed a Pap test for me in the past, he would always ask a female staff member to come in and stand by." **Participant B** highlighted in her narrative the presence of a female assistant during examinations conducted by a male healthcare provider and gave positive comments:

“When I needed to undergo examinations of sensitive areas, (the female doctor assistant) would say, ‘I will stay in this space with you.’ I have a very good impression of that.”

In summary, these findings address the research question by showing how participants experience patient-centred communication through practices such as consent obtained at each procedural step, respectful and dignified treatment, and the appropriate notification of chaperones. These practices make patients feel that their privacy and bodily autonomy are respected and contribute to an overall positive experience of the gynecological examination.

#### **4.2.2 Clear, Step-by-Step Communication**

Another patient-centered communication strategy frequently mentioned by the participants was the use of clear, step-by-step explanations before and during gynecological examinations. Participants reported that such explanations reduced uncertainty and increased predictability by making the examination process more transparent. These practices included checking patients’ understanding at different stages, describing upcoming procedures, and offering continuous updates throughout the examination. Participants recounted that, during the examinations, some healthcare providers offered real-time verbal feedback, including advance notifications before physical touching, ongoing and repeated reminders, and continuous updates throughout the procedure. Participants repeatedly noted that these “pre-touch” notifications made them feel respected and helped reduce their nervousness and described all these strategies as reassuring, as they helped them feel more informed and in control during the examination.

The participants who described the explanations as “detailed” consistently expressed positive evaluations of their communication with healthcare providers. They recalled being informed about what the procedure was for, what instruments would be used, what the patient

should expect, and the specific steps they would take on the patient's body. They expressed that this kind of explanation allowed them to mentally prepare for procedures that were otherwise unfamiliar. According to participants' accounts, their healthcare providers often assessed patients' prior knowledge before determining the level of detail to provide. First-time patients typically received more thorough and comprehensive explanations before the procedure began. Participants with previous gynecological examination experience also described receiving detailed explanations and expressed appreciation for this practice. Beyond verbal explanations, several participants also recalled that being shown the speculum before insertion, which helped reduce anxiety. **Participant E** mentioned that her healthcare provider explained the purpose of the instrument and how it would be applied to her body, which she perceived as calming and informative:

The doctor explained to me, one by one, what each of the instruments was for and how they would be used, and then she began the examination.

Similarly, **participant G** described similar experience, and described how this practice shaped her examination experience:

Whether it was my first examination or a follow-up, they explained to me every time what a Pap test is for, what its purpose is, and how the procedure works. They started with a brief introduction. If I had further questions, they would explain it in more detail... Throughout the entire examination, the doctor would tell me what he was going to do next while he was doing it. For example, "Next, I'm going to touch your shoulder," or "Next, I'm going to insert the clamp," and so on. He would also explain why each step was necessary, such as, "This movement is to examine this particular part of your body."

The participant reported that giving the rationale behind each step helped put her at ease and reduced her anxiety, ultimately leaving her with a positive overall experience:

This made me feel very comfortable and reassured, both physically and psychologically. And I felt respected. I didn't feel like a 'pig waiting to be slaughtered,' lying there helplessly. (The healthcare provider) wasn't rushing through the examination; he genuinely respected me, explaining each step beforehand. I felt that my feelings were

taken seriously, not just my body. It made me feel that I was communicating with a person, not just undergoing a medical procedure.

Participants also highlighted the pre-descriptions of potential sensations before healthcare providers performing certain steps. These warnings about possible discomfort or pain helped set expectations and reduced anxiety.:

The doctor said to me: “I’ve inserted the speculum now. Next, I’m going to make a movement that will cause it to expand. You may not feel much pain, but you will feel a sense of pressure. If you feel uncomfortable, please let me know right away.”

**(Participant B)**

**Participant H** reported a similar experience, noting how the doctor explained the sequence of actions and alerted her that one step might feel uncomfortable but would be quick. From the patient’s perspective, these advance explanations reduced fear associated with unpredictable sensations.

Other participants added nuance by describing variation in the extent of real-time feedback provided. Some recalled receiving immediate verbal reassurance during the examination; however, they recognized that such feedback depends on the provider’s personal communication style, and their ability to offer on-the-spot assessments. **Participant A** described expressing a desire for verbal updates during her ultrasound but not receiving any feedback from the person conducting it. She acknowledged that the technician might not have had the expertise or the authority to provide diagnostic information. Nevertheless, what she expected was basic informational sharing during the process, rather than being left completely unaware of what was happening.

The person doing the ultrasound usually doesn’t answer more specific questions during the exam. They might respond to very general questions, but when I asked about details, like the size of my ovarian cyst or how it had changed, they said that information would be in the report. Even though I already knew where the cyst was, not being able to get clear answers during the scan made the experience psychologically stressful for me.

**(Participant A)**

By contrast, **participant F** said she was pleasantly surprised when a healthcare provider took the time to verbally reassure her that her cervix appeared healthy, something she had rarely experienced before, neither in China nor Canada.

The specialist would actually describe what she was seeing during the exam. She told me, “I can see your cervix now,” and explained that it looked completely normal and healthy, with nothing abnormal to worry about. She was the only doctor over the years who verbally described what she was observing.

#### **4.2.3 Responsiveness and Emotional Reassurance**

The participants also valued the actions of healthcare providers showing attentiveness to patients’ verbal and non-verbal cues, as well as the subsequent actions that offered emotional comfort, reduced anxiety, and conveyed a sense of human warmth. The majority of the participants described providers’ careful observation of patients’ signs of discomfort, emotional tension, or pain during the examination. Given that patients’ expressions of discomfort were sometimes subtle, the healthcare providers used frequent check-ins asking about their feelings, comfort level, pain, or emotional state throughout the examinations:

(The healthcare provider) keeps saying things like, “tell me if anything hurts, tell me if you’re not comfortable, tell me if you want to stop.” He repeats these reminders throughout the exam so that if I feel any discomfort or want to pause, I’ll make sure to let him know. **(Participant G)**

For this participant, such repeated verbal check-ins signaled that the provider was attentive to her physical and emotional experience, while also actively encouraging her to express discomfort or concerns. This communicative practice positioned the patient as a participant rather than merely a recipient of care. Similarly, **participant E** noted that her healthcare provider suggested using a numerical scale from one to ten to describe her pain level, which helped the provider assess her condition and decide on appropriate adjustments during the examination.

Throughout the interviews with the twelve participants, none reported experiencing extreme pain during gynecological examinations. Healthcare providers' actions mainly included adjusting the position, asking how the patient felt now and saying the examination would end quickly, asking the patient to tolerate the discomfort for a bit. The participants generally showed satisfaction towards the responses as they said the healthcare providers showed care towards their feelings, making them feel valued and respected.

Beyond managing physical discomfort, participants also emphasized the importance of verbal emotional reassurance, particularly in the form of explicit validation and empathetic responses. When patients express discomfort or embarrassment toward the examination itself, some providers attempt to acknowledge those feelings and communicate understanding:

When I lay down on the examination table, I felt a bit uncomfortable, so I told them directly. I used a slightly joking tone and said, "This really feels a bit embarrassing for me." The doctor and nurse responded with understanding, saying they also recognize that the procedure can feel awkward. But they reassured me, explaining that it's okay, the process is quick, and that it's a routine, scientific procedure that would be over soon.  
**(Participant L)**

For this participant, such reassurance was perceived as both useful and appreciated. By acknowledging her embarrassment rather than dismissing it, the providers moved beyond a strictly biomedical approach and responded to her emotional experience. This kind of validation helped ease the vulnerability that often comes with gynecological examinations and reflects a communication style that participants perceived as more patient centred.

Participants further noted that the reassurance extends beyond verbal communication and is also conveyed through nonverbal cues. For example, the provider's tone of voice can shape the atmosphere of the entire process. Many participants described their healthcare providers' tone as

kind and friendly, which made them feel a sense of closeness. **Participant F** mentioned that her OB-GYN was very warm and approachable, which made her feel genuinely comfortable:

I think a doctor's attitude and approachability are very important, especially in gynecological care. They should help women feel more at ease and at least provide some reassurance.

Besides, eye contact was also highlighted as meaningful, particularly during the phases of the consultation when physical positioning allowed for it. **Participant B** noted that she felt disrespected when her family doctor only looked at the laptop rather than at her, leading her to question whether the provider had truly listened to her or taken her concerns seriously:

For example, when he came into the room and made some small talk, he was looking at his computer screen, even when talking about non-medical topics. When he didn't look at me, I subconsciously avoided eye contact as well. That made the communication feel awkward, like there was already a barrier between us, and the atmosphere didn't feel very natural.

This experience illustrates the importance of eye contact in communication, as it signals that the provider values the patient's opinions. Furthermore, several participants reported that a calm tone from the healthcare provider could have a soothing effect: "Here [in Canada], I feel the doctors' attitude is quite kind and not rushed. That also reassures me; their calmness influences me and makes me feel less anxious." (**Participant J**)

Taken together, the combination of responsiveness and emotional reassurance contributes to patients feeling of being treated as a person, not just a case. The patient-centred approach, highlighted by many participants, is central to their perception of the effectiveness of these reassurance strategies. **Participant G** stated, "I don't want to feel like a helpless lamb on the exam table, being handled however others want." Her reflection highlights how the physical vulnerability of the exam can easily translate into psychological vulnerability if providers treat the procedure as mechanical or routine. She stressed the importance of "more humanization,

person-centered care,” where doctors recognize that “everyone is unique, and the exam shouldn’t be treated as a routine task.” What mattered to her was not only the technical correctness of the procedure but the provider’s mindset, whether the doctor saw her as an individual rather than simply “the next one.” This approach allowed her to feel she was “communicating with a real person rather than going through a cold medical procedure.”

Overall, participants consistently described how these reassurances reshaped their emotional experience by reducing anxiety, fostering calmness, and encouraging open communication. These effects, which contribute to the sense of being treated as a person, perfectly resonate with the principles of patient-centred communication, signaling that the patient’s experience matters just as much as the clinical task.

#### **4.2.4 Relational and Personalized Communication**

The final aspect of patient-centred communication identified by participants was relational and personalized communication, which involves healthcare providers building a trusting relationship to enhance the patient’s examination experience. This form of communication often includes discussing non-clinical topics and adjusting the style or content of communication according to the patient’s personal background. For example, **participant K** described that her healthcare provider asked specific questions based on her broader health history, even if not directly relevant to the immediate procedure. Such inquiries were interpreted by the participant as conveying a sense of thoroughness and care. Overall, participants expressed acceptance of and positive attitudes toward informal, personalized exchanges, although sometimes with a gradual process of adapting to this communication style.

When discussing relational and informal communication, participants emphasized that providers sometimes shared personal experiences or engaged in casual dialogue to strengthen emotional connection and express empathy, not only as medical professionals but also as women. These relational strategies helped reduce the perceived distance between patient and provider and fostered a more relaxed atmosphere. Such conversations typically centered on aspects of personal identity, background, and emotional experience, reinforcing the sense of being treated as a whole person rather than a procedural case.

**Participant F** described her feeling as particularly comfortable because her OB/GYN engaged in ongoing personal conversation during the examination. By asking about her job, children, and daily responsibilities, the provider “felt very personal” and created a sense of being “seen” beyond the medical context. She also noted that her healthcare provider’s validation of her contributions as a mother who both works and takes care of two children communicated empathy. This relational style of communication helped the participant feel the physician was attentive to her life circumstances and her overall well-being, contributing to her satisfaction with the examination. Similarly, **participant G** described how her doctor made the entire procedure feel “lighthearted” by incorporating gentle humor:

This doctor made the whole process feel very relaxed. He even joked, ‘I’m going to see everything in a moment, so don’t worry about it,’ and I told him I was completely okay and didn’t feel much psychological pressure. He kept communicating with me in a light, joking manner, and I felt that, since he was really familiar with me, he was using this approach to ease my anxiety about undressing and being examined.

Humor here functioned as an interpersonal communication strategy to diffuse tension, signaling ease, and approachability during an otherwise intimate and potentially awkward encounter. At the same time, the physician adapted his communication to the patient’s educational background:

Because I had told him earlier that I was doing a PhD, he was especially eager to explain why he was doing certain things and what each action was meant to examine. He talked almost continuously, which I felt was also a way of easing my anxiety and uneasiness.

**(Participant G)**

While many participants appreciated these relational strategies, some also described an initial sense of discomfort or confusion, particularly when such communication contrasted with their prior medical experiences in China. **Participant I**, who previously worked as a doctor in China, demonstrated a sense of unfamiliarity by introducing informal talk into clinical practice. She explained that she initially had to adapt to this communication style because it was almost nonexistent in her original cultural context, both personally and professionally, and is often considered irrelevant or unprofessional in Chinese medical settings:

Culturally, as a Chinese woman, the doctors I grew up with never did this. They just did the examination and nothing more. Talking about what I'll have for dinner later has nothing to do with the exam.

At first, she found healthcare providers' small talk in Canada puzzling and unnecessary because it did not seem connected to the clinical task. However, over time and with increased exposure, she began to reinterpret these interactions as intentional strategies to reduce anxiety, redirect attention, and create a more relaxed atmosphere during intimate examinations. She further noted that this approach not only made the procedure more comfortable for patients but also helped the provider perform their work more smoothly. After recognizing this "turning point," she adapted her own responses as well, saying, "Once I understood this, I started to go along with the jokes too." The participant's dual identity as both a patient and a previous healthcare provider offered a more nuanced perspective, as she was able to draw on her professional experience while simultaneously reflecting on her experiences and expectations as a patient. This account also shows that although relational communication may feel culturally

unfamiliar at first, it can become meaningful through experience and cultural learning, shaping how immigrant women interpret communication during intimate medical encounters.

However, there are still cases where Chinese immigrant women perceive certain forms of small talk as inappropriate and feel uncomfortable about it during the gynecological examination. **Participant B** recalled that her provider initiated a conversation about politics, a topic she found sensitive and had little interest in discussing. Noticing that she did not respond, the provider eventually stopped, but the interaction left her feeling uneasy rather than reassured. This example not only reflects the need for patients to adapt to the small-talk culture in Canada but also highlights the importance of carefully selecting topics if healthcare providers intend to use small talk as a reassuring strategy. Poorly chosen or sensitive subjects may undermine the intended effect of relational communication and even heighten discomfort during an already vulnerable clinical encounter.

In conclusion, relational and personalized communication was perceived as playing an important role in building rapport and trust between healthcare providers and patients. By shifting communication toward a more casual, everyday form of dialogue, providers helped ease patients' nervousness and gently diverted their attention during gynecological examinations. At the same time, by obtaining more information and ideas from the patients themselves, the healthcare providers could adjust both the topics and the style of discussion to make the conversation more personalized and flexible, tailoring their approach to different individuals. Participants perceived such practices as reflecting a patient-centred approach, in which patients' feelings, preferences, and comfort were prioritized.

#### **4.2.5 Divergent Perceptions and Patient-Initiated Strategies**

Though the participants reported an overall positive attitude towards the patient centred communication strategies from the healthcare providers, there are two emerging patterns that differ from the dominant discourse.

First, some participants interpret these reassurance strategies as having limited or no effect on easing their tension during gynecological examinations. Two participants stood out from the others, believing such reassurance has minimal impact on reducing their anxiety. They viewed anxiety as something that can only be managed internally and rarely influenced by external factors:

There isn't a particularly good way to avoid the discomfort. If you tell the doctor, "This really hurts," do you mean, "Should we stop?" or something else? But I don't have that intention. So, I feel that in this situation, there's no need to have the doctor deliberately comfort me. **(Participant D)**

This account reflects a medical, task-oriented perspective held by these participants, with human interactions having limited effect:

But I wonder if this can really ease my nervousness. Not necessarily. She may have tried, but whether I feel nervous or not cannot be resolved just by her few words of small talk." **(Participant G)**

Together, these accounts suggest that while healthcare providers may intentionally employ reassurance and informal conversation to reduce anxiety, the perceived effectiveness of these strategies depends heavily on patients' personal dispositions, coping styles, and interpretations of the clinical situation.

Second, patients' proactive use of interpersonal communication strategies to negotiate the tense atmosphere during the examinations. And this behavior emerged as a notable contrast to the usual focus on how healthcare providers utilize these strategies, like humor and small talks, to strengthen the relationship with the patients. Several participants described deliberately using a

joking tone to express their embarrassment, hoping this light-heartedness could break the awkward atmosphere. They suggested that sometimes the conversations they initiated were not intended to obtain an answer, but rather to adjust the emotional climate of the room. As **participant A** explained, she intentionally initiated small talk to ease her own nervousness.

**Participant E** described a similar experience. In her case, she raised a question to the healthcare provider as a way to soften the atmosphere. However, the provider initially did not understand her due to unfamiliarity with the terminology. This misunderstanding momentarily discouraged her from continuing, as her goal was not clarification but emotional relief, and the difficulty in expressing herself increased her embarrassment. With the provider's continued encouragement and willingness to clarify, they were eventually able to identify the medical instrument she was referring to. Reflecting on this moment, **participant E** noted:

She was probably trying to get me to continue talking; otherwise, I wouldn't have kept going. I felt that if she hadn't wanted me to say more, I probably wouldn't have continued.

This experience highlights the significance of active engagement and positive responses from healthcare providers, showing that their encouragement can increase patients' willingness to express themselves, even when the initial purpose of speaking was simply to ease the tension rather than to seek information. In this way, patient-initiated humor and small talk functioned as a strategy for managing vulnerability, while provider responsiveness played a key role in sustaining these communication efforts.

While patient-centered strategies helped reduce stress and foster trust, participants' experiences also reflected the influence of their cultural beliefs, which shaped how they perceived and interpreted gynecological care, leading to the exploration of the impact of cultural beliefs in shaping their gynecological examinations in the next theme.

### **4.3 Cultural Beliefs Shaping Perceptions of Gynecological Care**

In reflecting on how they perceived healthcare providers' communication strategies during gynecological examinations, the participants critically considered the role of their personal and cultural backgrounds in shaping these perceptions. Overall, they reported that they did not experience targeted attention toward their specific Chinese cultural background. Nevertheless, they consistently expressed positive evaluation of healthcare providers' attitudes and communication skills. These were mainly reflected in practical language accommodations, such as speaking at a slower pace and using simpler words, as well as patient-centred communication practices, including responsiveness to patients' concerns. Participants further suggested that it is neither realistic nor necessary for healthcare providers to possess detailed knowledge of every ethnic or cultural background. Instead, what mattered more to them was a caring and polite attitude during communication. Within this context, participants generally did not expect or require additional culture-specific accommodations during the examinations.

Rather than expecting healthcare providers to learn extensively about their cultural beliefs and values, participants tended to adjust their own mindsets to align with clinical communication practices in the Canadian medical context. At the same time, participants acknowledged the influence of their cultural backgrounds on their communication experiences, and their perceptions of healthcare providers' communication practices were shaped not only by individual expectations but also by broader cultural norms, including attitudes toward sexuality, levels of linguistic proficiency, and prior healthcare experiences.

#### **4.3.1 Sexuality, Modesty, and Stigma**

Most participants acknowledged the presence of Chinese cultural beliefs related to stigma surrounding sexuality and admitted that these beliefs had influenced their experiences. However, participants emphasized that they had actively distanced themselves from these beliefs; if not completely, then at least to the extent that they no longer prevented them from participating in gynecological examinations.

Across participants' narratives of gynecological examinations, a recurring linguistic pattern is the use of indirect and euphemistic expressions when referring to body parts and sexual health, often combined with strategic code-switching into English. For instance, in **Participant L's** account, rather than using explicit anatomical or medical terminology, she consistently relies on generalized or socially acceptable terms such as “下体” (lower body), “隐私部位” (private part), and vague referents like “那个地方” (that place) or “这个东西” (that thing) to refer to the vagina. At the same time, she frequently shifts into English when discussing medical or sexual concepts. These English insertions tend to occur at moments when the content becomes more intimate or clinically specific, for example, in “更换 sex partner” (change sex partner). This pattern of alternation reflects not only bilingual competence but also an ongoing negotiation between cultural frameworks: while Chinese is associated with modesty and social taboos surrounding topics related to sexuality, English enables access to a more biomedical and normalized discourse of sexual health.

Similar patterns are observed across other interviews. **Participant H** described intimate conditions using indirect language, such as “下面长了个囊肿” (a cyst grew down there), rather than precise anatomical terms, like “A cyst developed on my mons pubis.” Such linguistic choices point to culturally embedded norms of modesty and restraint in discussing sexual and

reproductive health. However, participants also emphasize that this indirectness is not solely a cultural preference but can become a practical communication barrier in cross-linguistic healthcare settings. For example, **participant L** recounts that her Chinese friend “不知道该怎么说...或者是否有比较文雅的方式来讲说‘我的生殖器’或者‘我哪里不舒服’ ((I) don’t know how to say it... or whether there’s a more elegant way to refer to ‘my genitals’ or ‘where I feel discomfort.’),” and was therefore unable to independently seek care, and need to rely on others to communicate on her behalf. This highlights how the lack of accessible or socially acceptable vocabulary for intimate body parts in a second language may delay care-seeking among immigrant populations.

Besides, participants consistently attributed the stigma surrounding sexuality to the lack of sexual health education in China, neither from family nor from school, “not even discuss related issues with mothers” (**Participant L**), to explain the reason behind of lack of sexual health knowledge and potential reluctance to discuss sexual health issues. They indicate that early socialization in the Chinese society influences their openness about sexuality and reactions during gynecological care, although these beliefs and behaviors may change over time. For example, **participant A** reported misinterpreting healthcare providers’ questions regarding sexual activity, which she attributed to her limited knowledge and unfamiliarity with relevant terminology:

From childhood to adulthood, we never received any education in this area. Everything had to be learned on our own. So, I think this more or less affects how I respond during medical visits, especially when answering doctors’ questions. For example, my endometriosis required the doctor to ask a lot of background questions to decide on a treatment plan, including questions about my sexual activity. At the time, I said I wasn’t very active, being very straightforward about it. The doctor then asked when the last time was, and I said maybe last month, and he said, “Then that counts as active.” Definitions like this are very vague for us. Growing up, we never received any formal education in

this area; it was all self-taught. So, I think this definitely affects how I answer doctors' questions during visits.

This account illustrates how the lack of sexual health education contributed to feelings of uncertainty or discomfort during clinical communication. At the same time, some participants described gradually addressing these knowledge gaps through exposure to women's health and sexual health information after immigration. **Participant G** reflected that most of her understanding of women's and sexual health was acquired through healthcare providers in Canada, a process that did not resemble formal sex education but nevertheless filled substantial knowledge gaps. Having arrived in Canada as a graduate student in her early twenties, she felt she was learning foundational health information at an age when many Canadian peers had long been exposed to it:

Honestly, most of what I know about women's health, including sexual health, I learned from doctors here in Canada. When I came for graduate school at twenty-two, I hadn't had a gynecological exam before, and I knew almost nothing about things like birth control. In China, doctors rarely bring up these topics. My first doctor here patiently explained everything to me, and I think the gaps in knowledge and language reflect differences in cultural background.

**Participant L** also attributed her embarrassment during the gynecological consultations to a lack of sexual health education during her upbringing:

I was raised in a very traditional Chinese family, and as someone from an East Asian culture, discussions about sexual activity, STI screening, or prevention are generally very conservative. Mothers or female relatives would never proactively talk about it, and even doctors in China wouldn't bring it up. Even though I now know this information is important for me, if I were in mainland China, I wouldn't actively seek out these tests, nor would I have access to channels to learn about them.

The lack of sexual-health education, combined with cultural conservatism around sexuality, contributed to participants' feelings of embarrassment and reluctance during the examination. These factors collectively shaped what participants described as a sense of modesty, often expressed through silence, withdrawal, or hesitation when interacting with

healthcare providers. This modesty was also reflected in their approach to pain: several participants believed that discomfort during gynecological examinations “should” be tolerated, viewing endurance as a normative expectation:

The education I received growing up was that for minor illnesses or small pains, you are supposed to endure them. If you endure for a while, they will pass. There was nothing that justified crying out or saying that you were in pain. **(Participant B)**

This ideology was further reinforced by Chinese social media discourse, where gynecological examinations are frequently portrayed as inherently painful or shaming. Participants recalled seeing descriptions using terms such as “extremely painful” or “humiliating,” which shaped their initial expectations and led them to anticipate that the only appropriate response was to “undergo and endure.” **(Participant B)** These discourses not only amplified fear and reluctance but also normalized the idea that expressing discomfort might lead to judgment from healthcare providers or others.

All these reflections illustrate how the absence of comprehensive sexual-health education produced hesitation and uncertainty when communicating with healthcare providers in Canada. Across the interviews, participants did not describe experiencing sexual-health stigma in the Canadian context; rather, they emphasized that unfamiliarity, rooted in their earlier cultural and educational environments, contributed to feelings of reluctance and embarrassment. Participants further noted that any perceived stigma tended to diminish over time as they became more familiar with Canadian medical norms and expectations. **Participant L** described that she only became comfortable seeking gynecological examinations and openly discussing sexual health concerns after arriving in Canada. She suggested that this ease would not be transferable back to China, highlighting how cultural beliefs and social norms create a barrier that becomes more visible when another cultural environment is not present to serve as a buffer.

In China, or in my upbringing, these topics are too embarrassing to bring up and rarely mentioned. But in North America, the environment feels more open and accepting toward women my age. Conversations about sexual activity or gynecological health are more natural, and I feel it's okay to talk about my concerns. Therefore, even if I've had this Pap test now, in the context of China, I probably wouldn't have done it voluntarily. The willingness to take this test feels specific to my contacts here in North America; it's really something shaped by the North American context.

Most participants suggested that they had largely moved beyond sexuality-related stigma and stressed the importance of actively and openly express their needs to ensure their physical wellbeing. Many attributed the disengagement from the stigma and shame to the gradual accumulation of health knowledge, exposure to medical or health-related education, and immersion in contexts where sexual health concerns were treated as legitimate medical issues rather than sources of shame. And at the same time, acknowledging the cultural beliefs and sexual stigma they grew up with, participants also strongly encouraged active expression of their feelings of pain, discomfort, or concern: "as a patient, we should try our best to get rid of this sense of shame. It's our own body, and if something feels wrong, we need to express it in time instead of overthinking whether it is appropriate or not." (**Participant B**) Other participants made similar statements, emphasizing that patients should consciously work to move beyond feelings of shame, since understanding and communicating about one's own body is essential for receiving proper care. Furthermore, **participant G** described how, over time and through exposure to the more open and communicative environment in Canada, she shifted away from withholding her discomfort and began speaking up about pain and other concerns during medical encounters.

Now I choose to speak up my feeling of discomfort promptly. At first, I might have thought, "I can just endure it, no need to say anything." But over time, especially here, whether with friends, my partner, or doctors, people keep emphasizing that if something is uncomfortable, I should express it. Gradually, I've realized that speaking up isn't a big deal and doesn't need to be stressful. After all, it's my right; I should be able to express my feelings rather than forcing myself to stay silent.

The cultural background also introduced a subtle gender preference for female healthcare providers, although the degree and underlying reasons varied across participants. Most participants reported they do prefer female providers but remain flexible and can accept male providers when necessary. Many participants felt that they were not strongly influenced by the traditional belief that men and women should be socially separated, and they adopted a more open attitude toward gender differences in clinical settings. And there're also participants who emphasized a common belief among Chinese people that, from a medical perspective, gender does not matter in the eyes of healthcare providers. This reflects their trust that professionals will not treat them differently based on gender. Although some unease might still arise, they would try their best to overcome it. And beyond the embarrassment associated with cross-gender interactions, the main reason for preferring same-gender providers were the sense of relatability. Participants believed that, as women, female healthcare providers would have better empathy, a deeper understanding of their concerns, and a greater ability to address their stress. For example, one participant E, shared that she would disclose more concerns to a female provider because she felt an emotional distance with a male provider. Another **participant (H)** referred to this idea as “gender matching,” describing the pattern of women seeing female doctors and men seeing male doctors as a common “norm.” There were also cases where participants consciously “sacrificed” their gender preference. For example, one **participant (K)** who does not speak English, prioritized language concordance over gender. She chose a healthcare provider who could speak Mandarin, even though this meant accepting cross-gender examinations, because linguistic accessibility was her most important need. Overall, participants expressed a clear but non-compulsory preference for female healthcare providers, grounded in comfort, perceived empathy, and a sense of communicative openness.

To summarize, participants balanced cultural expectations, personal comfort, and practical needs, such as language accessibility, when communicating with their healthcare providers. Overall, they emphasized empathy and professionalism, and taking these balancing characteristics as valuable in supporting Chinese immigrant women's engagement during gynecological care.

#### **4.3.2 Perception of Hierarchy and Doctor-Patient Relationship**

Answering the question regarding medical hierarchy, participants generally reported minimal deference toward healthcare providers, while still maintaining respect based on the belief that doctors occupy a higher position than patients within the medical system. While some participants described showing respect and deliberately avoiding challenging medical authority, most reported behaviors that diverged from the traditional doctor-patient hierarchy, e.g. preferring a more collaborative provider-patient relationship, and sometimes challenged providers' suggestions. This suggests that the influence of hierarchical cultural norms cannot be assumed to apply uniformly to all Chinese immigrant women,

Several participants discussed their perspectives on showing respect toward healthcare providers and accepting their recommendations, reflecting an underlying recognition of medical authority. **Participant L** described her belief that healthcare providers possess significantly greater knowledge and expertise in diagnosis and treatment. As a result, she indicated that she would follow all suggestions from healthcare providers, even when she did not fully understand the medical information provided. She further expressed a preference for a more passive patient role, which aligns with traditional representations of patients in Chinese cultural contexts. She was concerned that active participation might delay or interfere with healthcare providers' diagnostic processes:

The information provided by doctors is more authoritative than what I could find on my own. Following doctors' recommendations, rather than actively participating, seems to be the norm for me as a Chinese woman. It is also difficult to define what counts as 'active participation,' as it may influence doctors' judgments or be perceived as questioning their expertise. This could lead doctors to change the treatment approach, which may not be what they believe is most suitable. Because of these concerns, I prefer to follow doctors' advice and trust their professional authority. **(Participant L)**

Similarly, **participant H** talked about compliance with medical recommendations despite limited understanding.

The doctor just asked me if I had ever had a gynecological exam. I said no. At the time, she didn't explain what a Pap test was. When I asked, she gave some explanation, but I didn't really understand. Then she asked if I had had a Pap test; I said no, and she said, "Okay, I'll schedule one for you." It wasn't until I got home and looked it up that I understood what a Pap test was. But since the doctor recommended it, I went ahead and made the appointment.

This account illustrates how trust in medical authority can lead patients to prioritize professional recommendations over their own comprehension or active engagement in decision-making.

**Participant F** described a more ambivalent response to medical authority. She talked about an unsatisfactory experience with an OB-GYN and expressed distrust toward the examination results. However, rather than directly confronting the healthcare provider, she chose to seek a second opinion from another doctor. She attributed this indirect approach to her personality and a general discomfort with interpersonal conflict, which she also linked to Asian cultural influences:

This may be related to personality, combined with the influence of Asian culture. When I feel uncomfortable, I often do not immediately react by saying, 'I'm uncomfortable.' It may be about saving face or not wanting to directly challenge the doctor's authority. I cannot fully explain it; I am simply not very comfortable with having direct, face-to-face conflict with others.

This experience illustrates how respect for medical authority does not necessarily eliminate patient doubt but instead shapes how dissatisfaction is managed through avoidance of direct confrontation.

However, there are also participants who expressed a different perspective on the hierarchy in doctor-patient relationships, stressing the importance of patient agency. While acknowledging the existence of cultural beliefs of obeying and respecting doctors and valuing technical correctness and efficiency over emotional connection, participants also suggested that their sense of agency and autonomy tended to increase with age and accumulated experience. For example, **participant G**'s account reflects a preference toward a more equal and collaborative doctor-patient relationship. Rather than positioning doctors as authority figures to be revered, the participant framed respect as compatible with equality, emphasizing that medical expertise does not imply broader social or interpersonal superiority. While acknowledging doctors' greater knowledge in health-related matters, she rejected the notion of an inherently hierarchical relationship, instead conceptualizing clinical encounters as ordinary two-way interactions:

For me, I am more concerned with my own health condition than with holding doctors in excessive awe. I respect doctors and see them as people who help me, but I do not feel admiration or deference toward them... Therefore, when seeing a doctor, I believe the relationship should be equal: more like two people engaging in a normal conversation, rather than one occupying a superior position and the other a subordinate one.

Another **participant H** said that she was not influenced by hierarchical doctor-patient power asymmetry, as she perceived her relationship with healthcare providers to be fundamentally equal. This perception also shaped her expectations of care: rather than seeking empathy or emotional support from healthcare providers, she prioritized professional competence and efficiency. Several other participants expressed similar views. While this perspective moves away from a hierarchical doctor-patient relationship, the participants' primary

focus on provider competence may make them less aware of, or less concerned about, situations of provider-dominated, non-patient-centred communication, as they would interpret such interactions as functional rather than problematic. In other words, because they prioritize the provider's expertise and efficiency, aspects of care that relate to patient comfort, emotional support, or shared decision-making may receive less attention in their evaluation of the interaction

### **4.3.3 Cultural and Ethnic Matching**

Some participants showed preference towards healthcare providers of same, or similar cultural or ethnic background. As written in previous sections, for the purpose of getting Chinese-speaking healthcare providers, patients would sacrifice other factors like gender and location, as they think the language capability is their most urgent requirement. In such cases, even when providers were not from the exact same cultural or national background, for instance, if they were Canadian-born Chinese, from Taiwan, or had received medical education only in Canada, participants reported fewer communication barriers. Shared awareness of potential language difficulties enabled providers to adopt supportive strategies, such as using translation tools or offering additional verbal explanations to address gaps in understanding. **Participant K** described how having a family doctor who could communicate in Chinese substantially reduced communication barriers, even though there existed some problems like matching the name of the medication.

I couldn't speak any English at all, so I found a Taiwanese family doctor, which helped me overcome the biggest language barrier. However, there were a few times when I told him about medications I used in China, and he didn't fully understand the names because they were in Mandarin. In those cases, a translator is still needed to make sure he understood.

This case illustrates how linguistic accommodation by healthcare providers, even without shared national or cultural origins, can effectively mitigate communication challenges in clinical encounters.

**Participant A** recalled an experience in which language congruence significantly shaped the depth and quality of communication during her medical examination. She described that during an ultrasound appointment with a healthcare provider who could speak Chinese, communicating in her mother tongue led to a noticeable change in her emotional state and engagement: “when we communicated in our mother tongue, my mindset was noticeably different,” and she attributed this change more to a shared sense of cultural identification than to the provider’s individual personality. Importantly, the participant contrasted this experience with earlier encounters with the same provider, during which no Chinese was used and the interaction involved “very little actual information exchange.” When they later switched to Chinese, the provider “was willing to share more information” and offered additional explanations about medical changes, resulting in a more fluent and informative conversation. This case illustrates how shared language, and the perceived cultural familiarity embedded within it, can foster greater information sharing, reduce communicative formality, and enhance patients’ sense of comfort and engagement during clinical encounters.

This case also demonstrates how ethnic and linguistic congruence may influence the healthcare provider’s openness and communication strategies in clinical interactions. The shared cultural and linguistic background appeared to create a relational context in which the provider became more open and proactive in information sharing, offering more detailed explanations beyond minimal procedural communication. Rather than affecting only the patient’s emotional

state, linguistic and ethnic alignment seemed to facilitate mutual ease and familiarity, shaping the provider's level of engagement and communicative openness during the clinical encounter.

#### **4.4 Summary**

The research question of how Chinese immigrant women perceive healthcare providers' communication strategies during gynecological examinations can be answered from two perspectives: communication strategies used by their healthcare providers, and the cultural influences shaping these perceptions. The results highlight several common communication strategies, including both accommodative and patient-centred approaches, which satisfied most participants. The communication accommodation strategies mainly illustrate how providers address language barriers by checking patients' language capability, using simpler terms, explaining medical jargon, slowing their speech speed, or switching to the patient's mother tongue. However, these strategies do not always work effectively, as some patients still reported difficulties in understanding the information provided.

In addition, the patient-centred communication strategies elaborate on how providers help reassure patients and reduce stress during examinations. These strategies mainly include paying attention to privacy, using clear and easy-to-understand explanations, actively monitoring patients' reactions, responding to their concerns, verbally and nonverbally reassuring patients' emotional needs, and using individualized and personalized communication topics to demonstrate care and empathy. Similarly, some patients critiqued these strategies as unnecessary, as they believed their stress could not be mediated solely by providers' actions. Throughout these processes, the participants reflected active agency, as they sought ways to communicate effectively with healthcare providers, such as engaging in preparation and research, making guesses, and actively seeking accommodation as non-native speakers. When addressing stress,

they also proactively communicated their pain and discomfort for the convenience of providers, for example by initiating small talk or using humor to ease the atmosphere.

Participants also frequently reflected on their personal backgrounds, including experiences within the Chinese medical system, growing up in China, and broader cultural influences, which shaped their communication practices and overall examination experiences. These reflections were mainly articulated through three perspectives: cultural beliefs around sexuality, modesty, and stigma; perceptions of hierarchy in the doctor-patient relationship; and perceptions of cultural and ethnic matching. When discussing sexual shame, stigma, and modesty, participants often attributed these to limited sexual health education and conservative social environments in China. However, despite acknowledging the influence of sexual stigma, participants generally agreed that these impacts should be, or had already been, reduced for more effective communication and for the sake of their health. This process of change progressed alongside increased education and longer immigration experiences, indicating that participants would adjust their communication behaviors as they interacted more within the Canadian context. A similar shift was reflected in perceptions of the hierarchical doctor-patient relationship. Although participants recognized the influence of asymmetrical power, they increasingly valued equal or collaborative relationships, prioritizing personal health over hierarchical norms. The final subtheme concerns perceptions of doctor-patient ethnic matching. Some participants expressed a preference for healthcare providers of the same ethnic background to avoid language barriers and cultural misunderstandings. This finding suggests a sense of mutual comfort for both patients and providers, as shared cultural backgrounds allow both parties to feel more at ease. However, participants also indicated that achieving ethnic matching

sometimes required sacrificing other determinants, such as travel distance or provider gender, to accommodate this preference.

Overall, these findings suggest that communication during gynecological examinations is not shaped by healthcare providers alone, but emerges through the dynamic interaction between provider strategies, patient agency, and culturally situated perceptions. While accommodative and patient-centred communication practices play an important role in facilitating understanding and emotional comfort, their effectiveness is mediated by patients' prior experiences, cultural beliefs, and individual expectations. At the same time, patients are not passive recipients of care; instead, they actively negotiate communication, manage discomfort, and adapt their behaviors to navigate both linguistic and emotional challenges within clinical encounters. Therefore, communication should be understood as a co-constructed process, in which both providers and patients continuously adjust their practices within broader cultural and institutional contexts.

## 5. Discussion

This research aims to explore how Chinese immigrant women perceive the communication strategies used by healthcare providers during gynecological examinations in Canada, how their cultural backgrounds influence their perception of effectiveness of the strategies, and the extent to which these strategies address the barriers they faced. Existing literature suggests that the major barriers perceived by patients include heightened vulnerability during gynecological examinations and other culture-related factors, such as sexuality-related stigma, hierarchical doctor-patient relationships, and language barriers. Correspondingly, commonly identified communication strategies are generally categorized into two frameworks: the communication accommodation model and patient-centred communication, which emphasize recognizing patient vulnerability, providing personalized communication, treating women with dignity, and considering the gender of providers. However, while prior studies primarily focus on patients' experiences of encountering these barriers and on how healthcare providers adopt communication strategies to address them and function as reassurances, the findings of this study indicate that patients' agency in this process is largely overlooked. Communication adaptation is often framed as the sole responsibility of healthcare providers, neglecting the active efforts made by patients themselves to adapt and negotiate communication during gynecological examinations. That is, the findings show that the communication is co-constructed through healthcare providers' strategies, patients' cultural backgrounds, and patients' agencies.

In this section, the interview findings are discussed in relation to existing literature on communication accommodation, patient-centred communication, and the influence of cultural beliefs, with further discussion on how these theoretical models can be interpreted from the perspective of patients' perceptions. In addition, the emergence of patient agency in the findings

is examined, highlighting how patients proactively make efforts to adjust and navigate their gynecological examination experiences. And finally, implications of the research findings and limitations are listed for the reference of potential stakeholders for further applications.

### **5.1 Communication Accomodation Theory**

Though often framed as interpersonal interaction, the intergroup pattern remains salient in provider-patient communication, particularly in intercultural healthcare encounters, where both patients and healthcare providers bring with them group-based identities shaped by culture and gender (Baker & Watson, 2015; Pines et al., 2025; Watson & Gallois, 1998). This suggests that communication in clinical settings is not value-neutral; rather, both parties enter the interaction with distinct needs, values, and communicative abilities that shape how meaning is negotiated. As Gallois et al. (2018) argue, “Intergroup communication is a two-way (or multi-way) street, but it is often ignored in models of intercultural health communication.” This perspective highlights the intergroup nature of Communication Accommodation Theory, emphasizing that accommodation is co-constructed rather than unilaterally enacted by healthcare providers. This theoretical framing resonates with the findings of the present study, which demonstrate patients’ deliberate efforts to converge toward healthcare providers’ communicative styles in order to maximize interactional efficiency. While this provider-centric focus is crucial for promoting equity and accessibility, it risks oversimplifying accommodation as a unidirectional process, thereby neglecting the foundational Communication Accommodation Theory principle that accommodation is inherently mutual and relational. Such convergence reflects patients’ prioritization of health-related goals and their strategic attempts to minimize communicative barriers, rather than indicating communicative deficiency or passive compliance.

The study findings indicate that participants perceived and recognized convergent communication accommodation strategies enacted by their healthcare providers. These strategies included approximating linguistic patterns through vocabulary adjustment, tailoring message complexity to patients' levels of health literacy, facilitating turn-taking to allow patients to ask questions and check understanding, and conveying reassurance, empathy, and respect. Collectively, these practices closely align with the five accommodative strategies identified as particularly relevant to health communication: approximation, discourse management, emotional expression, interpretability, and interpersonal control (Gallois, Ogay, & Giles, 2005; Watson, Jones, & Hewett, 2016). These findings reflect the provider-led responsibility of communication accommodation, emphasizing how healthcare professionals adjust their language, pace, and informational depth to meet immigrant patients perceived communication needs.

However, further findings from this study challenge this asymmetry by demonstrating that immigrant patients are not passive recipients of accommodative efforts but actively engage in their own accommodative strategies to align with healthcare providers' communicative norms. Participants described deliberate preparatory practices, such as using digital technologies (e.g., ChatGPT) to familiarise themselves with medical terminology, anticipated procedures, and institutional expectations prior to clinical encounters. These preparatory efforts function as pre-encounter accommodation, enabling patients to reduce interpretability gaps and to participate more effectively in biomedical discourse during consultations. It falls into the approximation pattern of Communication Accommodation Theory (Giles, 2016). In addition, participants also reported proactive in-encounter strategies, including explicitly asking for clarification of medical terms and requesting further explanation when concepts were unclear. Rather than signaling communicative deficiency, these behaviors reflect strategic discourse management (Giles, 2016),

whereby patients actively negotiate meaning and seek alignment with professional communication styles. Such actions illustrate patients' efforts to bridge communicative asymmetries shaped by linguistic, epistemic, and institutional power differentials.

Overall, these findings supplement existing Communication Accommodation Theory based intercultural health communication literature by foregrounding patient agency as a form of accommodation, rather than framing accommodation solely as something “done to” patients. Importantly, recognizing patient-initiated accommodation complicates deficit-oriented narratives that implicitly position immigrant patients as communicatively lacking. Instead, it reveals how patients strategically adapt to dominant biomedical communication norms in order to access care, reduce uncertainty, and maintain interactional harmony.

## **5.2 Patient-Centred Communication**

The findings indicate that participants highly valued patient-centred communication strategies, including the protection of privacy, the provision of detailed information, the establishment of personal rapport, and emotional reassurance. From a patient-centred communication perspective, these practices function not merely as supportive behaviors but as mechanisms through which patients' autonomy, dignity, and emotional safety are recognized during intimate clinical encounters. Participants consistently emphasized the importance of receiving information prior to the examination, particularly regarding what to expect during the procedure and how to prepare, such as guidance on undressing and the use of coverings to maintain comfort and modesty. This anticipatory instructions before and during the examination aligns with Bay and Akin's (2022) findings that patients' self-esteem and anxiety levels are closely associated with their perceptions of bodily privacy, and that explicit reassurance and clear instructions regarding privacy before the examination positively shape these perceptions.

Similarly, Abou-Shabana et al. (2022) demonstrate that pre-gynecological-examination counseling sessions enhance patients' experiences by dedicating time to explain the purpose, benefits, and procedures of the examination, addressing misconceptions, and supporting informed decision-making. Building on this literature, the present study suggests that patient-centred communication extends beyond routine procedural instructions to encompass a relational and preparatory process that enables patients to cognitively and emotionally prepare themselves for the examination. By anticipatory communication and privacy assurance, healthcare providers can help reduce uncertainty and mitigate anxiety for patients throughout the gynecological examination process.

Another communication strategy discussed and valued by participants was the use of verbal cues to prepare patients for potential sensations by describing what they might feel before each intimate step of the examination. Participants reported that such warnings helped reduce anxiety by alleviating fear of the unknown and by establishing clear expectations for the procedure. In line with this notion for anticipatory warning, Carugno et al. (2020) examined patients perceived discomfort in response to different types of verbal warnings, specifically comparing phrases with unpleasant emotional connotations to more neutral, objective language. In their randomized study of 120 patients, participants were assigned to receive either unpleasantly framed warnings (e.g., "You are going to feel a lot of pressure") or objective statements (e.g., "I am going to introduce the speculum") and subsequently rated their experienced discomfort. The statistical analysis revealed a significant difference between the two groups: patients exposed to unpleasantly framed warnings more frequently reported the examination as "as painful as anticipated" or "more painful than anticipated," whereas those in the objective-phrases group more often described the examination as "pain free" or "less painful

than anticipated.” These findings underscore how micro-level linguistic choices can shape patients’ sensory and emotional experiences through mechanisms of expectation setting and emotional priming. While Carugno et al.’s study offers valuable insight into the effects of word choice, it primarily focuses on linguistic framing and does not account for other intervening factors, such as providers’ delivery styles, patients’ prior examination experiences, or individual interpretations of pain and discomfort. Extending this literature, participants in the present study emphasized that effective warnings shall be delivered prior to physical touch. Participants described such practices as enhancing their sense of respect and protecting their dignity during the examination. This finding aligns with existing research highlighting the importance of communication preceding clinician touch, especially in intimate care contexts. O’Lynn et al. (2017), in their review of the literature, further suggest that beyond procedural explanations, warm and relational communication that fosters a supportive atmosphere is essential to patients’ comfort and perceived quality of care.

And patient-centred care is never a one-way communication process, but a reciprocal interaction between healthcare providers and patients (Freytag & Street, 2022). Scholarship on patient-centred care over the past two decades has increasingly emphasized collaborative models that move toward a logic of “care with patients” rather than “care for patients” (Foster et al., 2007). Approaches such as patient education and self-management highlight patients’ active participation in their care processes, while the more recent “partnership in care” model positions patients as full members of healthcare teams (Pomey et al., 2015). That is, patient partnership has been conceptualized not merely as provider facilitation, but as patients’ proactive efforts to reconcile gaps between their expectations and their lived experiences (Clavel et al., 2021), actively signalled comfort, confusion, or concern and cooperated efficiently, during clinical

encounters. Similarly emphasized by Balint et al. (1993), patient-centred care should not be understood as provider-driven alone but as a jointly negotiated interaction in which both patients and clinicians influence each other's behaviours and mutual understanding. This interactional perspective is further reflected in Mead and Bower's (2000) conceptualization of patient-centred communication, which frames both patients and healthcare providers as individual persons engaged in collaborative processes of information gathering, decision-making, and emotional responsiveness. However, this mutuality is not always automatically achieved. Although patient-centred models often assume patient openness, the finding also acknowledges that patients may withhold information when trust in healthcare providers is lacking. This possibility introduces an important conditional dimension to patient-centred communication: mutuality depends on relational safety perceived by the patients during the communication process. Consistent with this concern, participants in this study indicated that a caring attitude and ongoing encouragement to express concerns directly influenced their willingness to disclose personal information and articulate opinions. In Grundström et al.'s study (2011), the young women expressed that they felt regain control and comfort when the process was continuously facilitated by the healthcare providers and provided with ample information regarding the processes. Trust, therefore, functioned as a mediating mechanism that enabled patients to move from passive compliance to active engagement. In this sense, the findings resonate with King and Hoppe's (2013) argument that best practices in patient-centred communication extend beyond information exchange to include emotional engagement to build trust and therefore enabling the patient participation. Together, the literature and findings suggest that patient-centred communication emerges through mutual engagement, where provider behaviours and patient responses continuously influence each other within a trust-based relational context.

### 5.3 Cultural Background

The cultural backgrounds have a consistent influence on the communication experiences of Chinese immigrant women during gynecological examinations. For instance, participants also showed empathy toward healthcare providers, demonstrating understanding of providers' "un-patient-centred" behaviors as shaped by a cultural background in which the doctor–patient relationship remains hierarchical and paternalistic. This resonates with existing studies indicating that patients from higher power distance cultures, such as Chinese culture, who perceive the doctor-patient relationship as more hierarchical (Pun et al., 2018; Siu, 2015; Yang et al., 2019), tend to be more tolerant of healthcare providers who use more directive and less interactive communication strategies to overcome communication barriers, perceiving such approaches as normal. This aligns with Liu et al.'s (2025) findings, which suggest that directive communication in hierarchical medical cultural contexts is not necessarily perceived as poor practice by patients but rather corresponds with culturally embedded expectations of professional authority.

However, the findings of this research suggest that the persistent influence of cultural beliefs, such as sexual stigma and deference towards doctors, tends to diminish with longer duration of immigration and increased exposure to education. A substantial body of literature has examined the relationship between mainstream acculturation and sexuality. For instance, Dang et al. (2019) found that mainstream acculturation (i.e., adopting mainstream Canadian culture) among young Chinese men and women in Canada was consistently associated with more permissive and less restrictive sexual attitudes, responses, and behaviours. In other words, Chinese immigrants in Canada may gradually embrace less stigmatized and more open sexuality-related beliefs as time in the host society increases and social acceptance expands. Supporting this, Blanc's (2022) review shows that Asian women held more conservative sexual attitudes and

less liberal sexual behaviours than Euro-Canadian women; however, across immigrant groups, including Asians in the U.S. and Canada, mainstream acculturation was generally positively associated with more liberal or permissive sexual attitudes. This suggests that longer residence in Canada and stronger identification with mainstream culture are correlated with reduced sexual conservatism.

However, an ideal or linear acculturation process does not exist for all individuals. Zhou (2012) identified a disconnect between Chinese immigrant women's evolving sexual behaviours and the ongoing silence surrounding discussions of sex. Although living in Canada introduces a new social context that reshapes sexual practices and meanings, participants' partial integration into the host society, combined with sustained transnational ties to China, meant that traditional Chinese norms continued to shape how these changes were interpreted. Consistent with this complexity, the findings of this study also reveal participants' active but selective efforts in cultural adaptation, particularly in relation to small talk practices in healthcare encounters. Many healthcare providers utilize personalized small talk as a strategy to help patients relax and build trusting relationships. According to this study's findings, while most participants accepted and even appreciated these social practices relatively quickly, some participants remained skeptical of their purpose, viewing them as unrelated or even inappropriate within a medical context. These observations further complicate Zhou's (2012) conclusion that acculturation is neither universal nor uninterrupted. Multiple interacting factors shape this process, and some may hinder immigrants from fully embracing more open sexuality-related beliefs, resulting in the persistence of sexual conservatism. Consequently, healthcare providers must remain attentive to varying levels of cultural acceptance and comfort, particularly when communicating with Chinese

immigrant women, to ensure that interactions are both inclusive and effective rather than assuming uniform acculturation outcomes.

Beyond the factor of acculturation level, another influential factor impacting Chinese immigrant women's beliefs about sexuality and related stigma is their level of health literacy. In the findings, several participants attributed their non-stigmatized views of sexuality to their medical education backgrounds, as well as to increased knowledge related to sexual health. Alhussaini et al. (2025) conducted a scoping review on health literacy among college students from diverse socio-cultural backgrounds and highlighted the potential roles of family and technology-driven solutions in enhancing health literacy. However, in this research, participants commonly recognized the ineffectiveness of family influences and prior public sexual education, while technology-based resources, such as AI, and education provided by healthcare professionals emerged as key channels for knowledge acquisition. More broadly, even beyond immigrant populations, interviews with 15 participants who had experience with gynecological procedures in Gopisetty et al.'s (2025) study indicated that preparatory actions, such as researching symptoms and related information and knowing what questions to ask, helped reduce anxiety levels. Furthermore, research has identified improved education as a critical need during well-woman visits, as it can enhance patients' health literacy, reduce examination-related fears, and promote follow-through with additional tests and treatments (Rickman et al., 2024).

## **5.4 Implications**

### **5.4.1 Theoretical Implication**

The study contributes to communication theory by extending Communication Accommodation Theory in clinical settings beyond a provider-centric framework, to incorporate

patients' efforts to converge toward their healthcare providers' communication styles in pursuit of effective communication. It also contributes to patient-centred communication models by re-emphasizing the mutuality of patient-centredness in achieving maximal communication efficiency. Furthermore, the findings complicate linear narratives of acculturation and cultural essentialism in immigrant healthcare communication, instead reflecting a non-linear and progressive process of cultural adaptation.

First, existing research applying Communication Accommodation Theory in healthcare contexts predominantly conceptualizes accommodation as a set of adjustment strategies employed by healthcare providers to converge with patients' linguistic needs, or with those of other healthcare professionals, to maximize communication efficiency and quality of care. In contrast, the present study shows patients' efforts as active participants in the convergence and accommodation process, both before and during gynecological examinations. Participants proactively adjusted their linguistic and cultural communication strategies by engaging in pre-clinic preparation through digital technologies, researching medical terminology in English, requesting clarification of meanings, and actively participating in shared decision-making. These practices demonstrate that patients also play an active role in converging their communication styles toward those of their healthcare providers, thereby reducing communication barriers. These reframing positions communication accommodation as a reciprocal rather than unidirectional process. Moreover, it challenges portrayals of immigrant patients as passive recipients of accommodation due to communication inadequacy. Instead, the findings highlight the agency and strategic competence exercised by this population, framing patients as active communicators who co-construct the meaning of clinical interactions and deliberately adapt to

dominant communication norms within a foreign healthcare context, thereby mitigating power asymmetries traditionally embedded in intercultural clinical encounters.

Second, the study's findings re-emphasize the humanization nature of patient-centred care, foregrounding interactional processes that foster empathy, trust, and respect. Rather than conceptualizing patient-centred communication as a fixed set of provider-led practices designed to meet immigrant patients' needs, this study demonstrates that patient-centredness emerges through the mutual engagement of both parties, shaped by trust developed within the communicative process itself. Moreover, the findings illustrate that patients' active participation is not spontaneous but actively cultivated through healthcare providers' reassurance and encouragement, indicating that patient agency is relationally produced rather than inherently exists.

And lastly, the findings complicate the narratives of either cultural essentialism in explaining communication barriers faced by immigrant patients, or the acculturation-based explanation towards the cultural adaptation to the medical communication in the Canadian context. For the former implication, the findings suggest that though the immigrant patients experienced and admitted the existence of impact of Chinese cultural beliefs like sexual stigma and medical hierarchy, more emphasized is their recognition of disposing the ideas to maximize their diagnosis experience and effectiveness. That is, the cultural beliefs may broadly exist, but the people's mind in realizing and resisting the negative impacts shall be also taken into consideration rather than simply complaining culture as obstacles. Besides, for the latter statement, as the participants indicated their disposal of cultural stigma ideas along with increased time in the host society and education, participants' experiences revealed selective and non-linear cultural adaptation, particularly in relation to intimacy, small talk, and expectations of

professional boundaries. This further suggests that cultural background should not be treated as a static variable nor acculturation as a linear progression, but rather as an ongoing, context-specific process shaped by health literacy, institutional norms, and individual social experience.

#### **5.4.2 Practical Implications**

At the clinical level, the study suggested that the healthcare providers shall recognize and take patient-initiated accommodations during clinical communication encounters and taken their efforts as a meaningful form of engagement rather than interpreting clarification requests or extensive questioning as indicators of low competence. That is, the healthcare providers shall not assume stereotypically the incompetency of all immigrant patients. Instead, a more equal and respectful attitude shall be employed to build more trustful and respectful provider-patient relationships. Furthermore, by inviting questions, validating patients' preparatory efforts, and acknowledging their active role in meaning-making, the healthcare providers can help redistribute communication authority and foster more power-neutral interactions, thereby helping the immigrant patients overcoming subtle cultural barriers and more openly disclose their opinions, making they be control of their autonomy. Treating patients as individuals rather than procedural subjects, by incorporating relational and personalized communication and conveying human warmth, not only improves emotional comfort but also facilitates disclosure, trust, and diagnostic efficiency. Clinicians should therefore attend not only to what is communicated, but how it is delivered, including tone, timing, and emotional reassurance. Besides, the study also emphasized the importance of anticipatory communication, particularly in intimate examinations. Providing clear explanations before physical touch, using neutral and descriptive language, and offering privacy-protective instructions were consistently described by participants as reducing anxiety, enhancing dignity, and helping to improve patient cooperation. These

practices should be understood not as optional “soft skills” but as core communication competencies in gynecological care. With regard to the use of translator to address language barriers, the findings suggest that timing and approach of suggesting the use are critical. The direct or unsolicited introduction of a translator may be perceived by patients as implying linguistic incompetence, rather than as a response to contextual or situational communication needs. It risks stereotyping and oversimplifying the patients’ backgrounds and overall capabilities. A more appropriate approach is to wait for the patient to actively request a translation or to gently confirm whether translative support is needed to ensure mutual understanding.

For a policy-inspiration perspective, the study demonstrates the need for more health education resources with the purpose of explanation and de-stigmatization, compensating for the potential previous lack of health education. In addition, the prominent role of technology-mediated self-education suggests opportunities for healthcare systems to provide institutionally endorsed, culturally sensitive preparatory resources, such as multilingual explanations, AI-supported information tools, or pre-visit educational materials. Doing so may help reduce interpretability gaps while minimizing patients’ reliance on potentially inconsistent external sources. Such resources could include multilingual, plain-language explanations of gynecological procedures, e.g., what a Pap test involves, what sensations to expect, and why it is recommended, guidance on common concerns or misconceptions, and explicit reassurance regarding privacy, consent, and bodily autonomy. Given participants’ frequent reliance on online self-education, the healthcare systems could also integrate institutional digital tools, such as clinic websites or AI-supported chat functions, that allow patients to review information, submit questions anonymously, or confirm understanding prior to appointments. And these resources

should also be culturally sensitive, use accessible language, and explicitly address privacy, consent, and patient agency. Embedding such materials into routine care, for instance by sending them automatically at the time of appointment booking, may help patients reduce uncertainty, support their preparedness, and decrease reliance on informal or potentially unreliable external sources. Overall, by providing standardized but adaptable educational content, healthcare systems may reduce the potential health literacy gaps.

## **5.5 Limitations**

The research has several limitations.

First, participants were mainly recruited through Chinese social media platforms and generally had higher educational backgrounds, with many having received postgraduate education in the US or Canadian context. This sampling characteristic may introduce bias related to participants' digital literacy and their greater acceptance of de-stigmatized perspectives on sexuality and sexual health. As research conducted by Aelbrecht et al. (2019) suggested that the quality of patient-physician communication is influenced by the patient's educational background and language proficiency, where patients who are well-educated and have higher language proficiency tend to have a greater chance of a positive patient-physician interaction. Furthermore, participants' willingness to actively engage in the interviews suggests that they represent a group with relatively higher self-confidence in expressing personal experiences and opinions. This characteristic may also be reflected in their reported communicative behaviours during gynecological examinations, such as active expression and self-advocacy. In addition, several participants had professional backgrounds in healthcare-related fields, which may have equipped them with greater emotional acceptance of intimate examinations and facilitated rapport-building with healthcare providers. Consequently, the findings may not fully capture the

experiences of individuals with limited health literacy, language barriers, or consistently negative healthcare encounters. Individuals more strongly constrained by conservative cultural beliefs or sexual stigma may be less willing to participate in interviews or to share such personal experiences with unfamiliar audiences and therefore remain underrepresented in this study.

Besides, the study relies on participants' accounts of clinical encounters, which are inevitably subject to recall bias and personal interpretation. For example, in cases where political issues were used as topics of small talk, participants interpreted such communication as inappropriate and uncaring. However, the intentions of the healthcare providers cannot be directly assessed, as these conversational attempts may have been intended as a trust-building strategy that failed, or may not have sufficiently considered patients' emotional boundaries. Moreover, future study can include direct observation of clinical interactions or healthcare providers' perspectives. The analysis in this study captured perceived accommodation and patient-centredness solely from participants' viewpoints, rather than examining interactional practices as they unfold in real time. This limits the ability to conceptualize accommodation as a fully bidirectional process or to systematically compare patients' interpretations with providers' communicative intentions. Meanwhile, the diverse cultural backgrounds of healthcare providers should also be taken into consideration, as they are active participants in the communication process, and their actions are influenced by their personal, educational, and cultural experiences.

Thirdly, as the interview asked participants to reflect on a single previous gynecological examination, their accounts tended to focus on comparative experiences between China and Canada. However, this design overlooks pregnancy-related care, which typically involves sustained, long-term interactions with an OB-GYN and the development of a continuous patient-provider relationship. It also fails to capture how patients' perceptions, needs, and

communication preferences may evolve over time, particularly across the course of pregnancy and the postpartum period. Therefore, future research may adopt a longitudinal design that follows patients across different stages of reproductive care, particularly pregnancy and postpartum, in order to capture how patient-provider relationships develop over time and how communication needs and expectations evolve. It may also broaden the scope beyond single-visit reflections to include ongoing interactions with OB-GYNs, thereby providing a more comprehensive understanding of continuity of care and its impact on patient experience.

Finally, the study focuses primarily on the communication processes that shape patients' emotional experiences during gynecological examinations; therefore, future research may focus on broader structural and institutional forces that influence the Chinese immigrant women's communication experience. These include factors influencing participants' willingness to attend examinations, as well as the professional norms and codes of conduct that guide healthcare providers' communicative behaviour. This analytical focus may limit insight into systemic failures, entrenched power asymmetries, or overt communicative breakdowns, all of which are equally important for understanding persistent inequities in immigrant healthcare communication.

## 6. Conclusion

The study explores Chinese immigrant women's communication experience during gynecological examinations, with particular attention paid to how patient-centred communication strategies and communication accommodation strategies are perceived by the participants and how these communication strategies are negotiated with the influence of their cultural beliefs. The study invited a group of 12 Chinese immigrant women who recently had gynecological examinations in Canada and utilized qualitative semi-structured interviews to gain in-depth understanding of the participants of their perceptions of the communication experience with their healthcare providers and critically reflect upon how these perceptions were formed based on their personal and cultural backgrounds. According to their narratives around the experiences, the participants stressed not limited to the interpersonal information-exchange technical function of communication, but delved deep into more relational intergroup dimensions, which is another significant perspective that shall be carefully considered for such intimate examination context. The study reaffirmed the humanization and relational nature of patient-centred Communication, indicating that Patient-centred Communication cannot be reduced to a simple checklist of provider-led behaviors that can be enacted accordingly. Instead, patient-centred communication emerged as a dynamic process, co-constructed through interaction between patients and healthcare providers, in which both parties actively contribute to the effective and positive examination experience. Furthermore, the study challenges the provider-centric narrative of patient-centred Communication and Communication Accommodation Theory, by suggesting the central role of patient agency in the medical communication. Participants described strategies they adopted, such as preparing questions in advance, requesting clarification of medical terminology, and actively negotiating comfort levels during examinations. These practices

indicate that patients are not merely accommodated but actively engage in communication to achieve mutual understanding. However, such agency was not exercised in isolation. Rather, it was fostered by healthcare providers' reassurance, encouragement, and openness to dialogue. It also re-emphasized the significance of trustful relationship built between the patients and the healthcare providers, which would further enable patients' capability in advocate for themselves and participating in the shared decision making, perfecting the ultimate vision of patient-centred Care.

Furthermore, from a cultural perspective, the findings suggest that participants did not experience culture as a fixed or dominant determinant of communication, but rather as a contextual influence that was continuously reflected upon, negotiated, and, in some cases, deliberately resisted. While participants acknowledged the impact of conservative sexual norms, modesty, and limited sexual health education in their pre-migration socialization, these influences were often framed as background conditions rather than dominant constraints on communication. Many participants emphasized personal responsibility for health and expressed a willingness to set aside culturally inherited discomfort in order to facilitate effective interaction with healthcare providers.

In terms of contribution, this research adds to immigrant health communication scholarship by centring Chinese immigrant women's voices and emphasizing the importance of intergroup nature during such intimate examinations. While existing studies often focus on structural barriers, language discordance, or access-related challenges, this study demonstrates that communication inequities may persist even among relatively well-educated, linguistically capable patients. By paying attention to subtle communicative dynamics, the research reveals

how Patient-centred Communication can be experienced as either empowering or alienating, depending on how communication is interpreted by people from different backgrounds.

Building on the findings and limitations of this study, future research may further advance understanding of immigrant healthcare communication by adopting broader methodological and analytical approaches. First, while this study centred on patients' accounts, future research would benefit from multi-perspective designs that incorporate healthcare providers' experiences, as well as direct observation or recording of clinical interactions. Such approaches would allow for a more systematic examination of whether Communication Accommodation Theory as a bidirectional and interactionally negotiated process and would help distinguish between perceived mis-accommodation and providers' intended communication strategies. And future studies may also expand the sample of participants to include more diverse and marginalized subgroups within the Chinese immigrant populations. Future research may purposively include individuals with limited health literacy, lower educational backgrounds, limited digital access, or stronger adherence to conservative cultural or religious beliefs related to sexuality to explore how structural vulnerability, cultural stigma, and communication barriers intersect to shape their healthcare experiences in Canada, particularly in intimate clinical contexts such as gynecological care.

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## **Appendix A: Interview Guide**

### **Topic 1: Experience of the most recent gynecological exam**

Main question: Can you tell me about your most recent gynecological examination? What was the experience like for you, from beginning to end?

#### ***Possible follow-up probes (only if relevant or mentioned):***

1. What are the moments that you felt particularly memorable to you?
2. How would you describe the way the healthcare providers interacted with you?
3. How did the communication during the exam feel to you overall?
4. If the doctor or nurse did something that stood out to you, how did you interpret that at the time?
5. When you think back on the interaction, what kinds of thoughts or feelings come up for you now?
6. As you noticed any emotional reactions during the exam, what do you think contributed to those feelings?

### **Topic 2: Discomfort and emotional responses during the exam**

Main question: During that examination, were there any moments when you felt uncomfortable, uneasy, or unsure?

#### ***Possible follow-up probes (only if relevant or mentioned):***

1. Can you describe what was happening at that moment?
2. How did you respond internally or outwardly at the time?
3. If the provider noticed your reaction, how did they respond?

4. If you chose not to say anything, what influenced that decision?
5. What do you think might make it easier for you to express discomfort during an exam?
6. Over time, have you developed any personal ways of coping with or managing those feelings?

### **Topic 3: Language and understanding in medical communication**

Main question: How would you describe your experience with understanding and using language when communicating with doctors?

#### ***Possible follow-up probes (only if relevant or mentioned):***

1. Were there moments when you felt unsure about what was being said or explained?  
Can you describe it?
2. How do you handle the situations where something is unclear to you?
3. If you've ever asked for clarification, how did the doctor respond?
4. As you mentioned that you prepare in advance for medical visits, what preparations have you done?
5. How do you feel that preparation affects your interaction with the doctor?
6. Can you recall a situation where preparation either helped or didn't help as much as you expected?

### **Topic 4: Cultural background and communication**

Main question: How do you think your cultural background plays any role in how you communicate with doctors or experience medical visits?

***Possible follow-up probes (only if relevant or mentioned):***

1. Are there certain topics that feel easier or harder to talk about?
2. How do you think your past experiences or upbringing have shaped those feelings?
3. Have you noticed any changes in how you communicate with doctors since coming to Canada?
4. Do you feel that healthcare providers are aware of or responsive to your background?
5. In what ways, if any, has that affected how comfortable or confident you feel during exams?
6. Have you developed any strategies to navigate or reduce discomfort related to these experiences?

**Topic 5: Views on cultural difference and patient-doctor communication**

Main question: What are your thoughts on how doctors communicate with patients from different cultural backgrounds?

***Possible follow-up probes (only if relevant or mentioned):***

1. From your perspective, what do you think of should doctors take cultural differences into account during medical encounters? Why or why not?
2. When you see a doctor, what kind of approach feels most respectful or helpful to you?
3. Are there specific ways you would like doctors to adjust, or not adjust, their communication or behavior?
4. Do you ever worry about being misunderstood or stereotyped during medical visits?
5. How do those concerns, if any, influence the way you interact with doctors?

## Appendix B. Ethics Approval

03/07/2025

**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**

Office of Research Ethics and Integrity

### CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

**Numéro du dossier / Ethics File Number**

S-06-25-11580

**Titre du projet / Project Title**

Exploring Chinese Immigrant  
Women's Perspectives on  
Communication with Healthcare  
Providers During Gynecological  
Examinations

**Type de projet / Project Type**

Thèse de maîtrise / Master's  
thesis

**Statut du projet / Project Status**

Approuvé / Approved

**Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)**

03/07/2025

**Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)**

02/07/2026

#### Équipe de recherche / Research Team

**Chercheur /  
Researcher**

**Affiliation**

**Role**

Yutong LU

Département de communication / Department of  
Communication

Chercheur Principal / Principal  
Investigator

Maria CHERBA

Département de communication / Department of  
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Superviseur / Supervisor

**Conditions spéciales ou commentaires / Special conditions or comments**

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## Appendix C. Consent Form (English/Chinese)

### Consent Form

**Title of the study: Exploring Chinese Immigrant Women's Perspectives on Communication with Healthcare Providers During Gynecological Examinations**

**Researcher**

Yutong Lu, Master's Student  
Department of Communication  
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**Supervisor**

Maria Cherba, Associate Professor  
Department of Communication  
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**Invitation to Participate:** I am invited to participate in the abovementioned research study conducted by Yutong Lu for the Master of Arts in Communication Thesis under the supervision of Professor Maria Cherba.

**Purpose of the Study:** The purpose of the study is to investigate experiences of Chinese immigrant women during gynecological examinations, focusing on the communication with the healthcare providers.

**Participation:** My participation will consist of taking part in an interview. During the interview, the researcher will ask about my personal experiences during gynecological examinations and my interactions with healthcare providers. She will also ask me to reflect on culturally competent communication strategies employed by healthcare providers, how these strategies influenced my experience, and what suggestions I may have to improve doctor-patient communication for Chinese immigrant women. I will participate in one interview lasting approximately 60 minutes, in person or online (via Zoom or Microsoft Teams). The interview will be recorded. I will review the transcript of the recorded interview within 1 week after the interview if I want to.

**Acceptance:** By selecting the option below, I agree to have the interview be recorded by:

- Both Audio and Video
- No, I do not agree to be recorded

**Risks:** My participation in this study will entail that I will volunteer personal information and discuss topics around gynecological examination experience, and this may cause me to feel discomfort or emotional unease. I have received assurance from the researcher that every effort will be made to minimize these risks, as I can choose to refuse to answer and to withdraw from the interview at any time when I feel uncomfortable. Additionally, I have been provided with a list of mental health supports and general health information resources compiled by the Government of Canada in this consent form, available at: <https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html>, for my use at any time.

**Benefits:** My participation in this study will contribute to a better understanding of Chinese immigrant women's experiences during gynecological exams and may inform policies and training programs to better support immigrant women's health needs.

**Confidentiality and Privacy:** I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for the researcher's Master Thesis and that my identity will be protected, as the researcher will handle all personal data confidentially and any identifiable personal information will be anonymized. Any identifying information, such as job titles, organization names, or specific personal characteristics, will not be asked, and be removed or modified if mentioned to protect my privacy.

**Conservation of Data:** The data collected (audio/video recordings and transcripts of interviews) and consent forms will be kept in a secure manner. All physical copies will be securely stored in a locked cabinet at the supervisor's office on uOttawa campus. All online content will be saved on the researcher's password-protected work computer and the secured server of the University of Ottawa. Upon the researcher's completion of Master of Art program, all digital files will be transferred to a password-protected, encrypted external hard drive stored in the supervisor's campus office for the remainder of the 5-year retention period. Identifiable video-recordings will be deleted as soon as interviews are transcribed, while the audio recordings will be kept for the five year retention period. At the end of retention, electronic files will be permanently deleted, and paper documents will be shredded.

**Voluntary Participation:** I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions before the acceptance of the thesis which expected to be in April 2026, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be removed from the dataset and not used in the study.

If I have any questions about the study, I may contact the researcher or their supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Office of Research Ethics and Integrity via email ([ethics@uottawa.ca](mailto:ethics@uottawa.ca)) or telephone (613-562-5800 ext. 5387).

It is recommended that I keep a copy of this consent form for my records.

I wish to review the transcript:

- Yes
- No

**Acceptance:** By selecting the consent statement below, I agree to participate in this research study.

- Yes, I want to participate.
- No, I do not want to participate.

## 知情同意书

研究主题：在加拿大的中国移民女性在妇科检查中医患沟通体验研究

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### 参与邀请

本人受邀参与上述由渥太华大学传播学硕士陆雨桐在导师 Maria Cherba 教授指导下开展的硕士学位论文研究项目。

### 研究目的

本研究旨在探讨中国移民女性在妇科检查过程中与医护人员的沟通体验。

### 访谈内容

我将参与本次半结构化访谈。访谈中，研究员将询问我在妇科检查中的个人经历、与医护人员的互动情况，并请我反思医护人员使用的文化敏感性沟通策略、这些策略如何影响我的体验，以及我对改善中国移民女性医患沟通的建议。访谈将以面对面或线上（通过 Zoom 或 Microsoft Teams）形式进行，时长约 60 分钟，并将被录音/录像。若需要，我可在访谈结束 1 周内查看转录文本。

### 录制许可（请勾选）

同意音视频录制

不同意录制

### 风险说明

参与本研究需分享个人经历及妇科检查相关话题，可能导致不适或情绪波动。研究员已承诺将尽力降低风险，与此同时我可随时拒绝回答问题或退出访谈。此外，本同意书还提供了由加拿大政

府编制的心理健康支持服务和一般健康信息资源清单（链接：<https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html>），可供我随时使用。

### **研究价值**

我的参与将有助于提升对中国移民女性妇科检查体验的理解，并可能为相关政策及培训项目提供参考，以更好地满足移民女性的健康需求。

### **隐私承诺**

研究人员已向我郑重承诺：我所提供的所有信息都将受到严格保密。我理解所有资料仅用于其硕士论文研究，且我的身份将受到保护：所有数据将被匿名化处理，涉及职位、机构名称或个人特征等可识别信息均不会被主动询问，若被提及也将被删除或修改。

### **数据保存**

研究数据（录音/录像、访谈转录文本及同意书）将被安全保存。纸质材料存放于渥太华大学校园内导师办公室的上锁文件柜；电子资料存储于研究员密码保护的工作电脑及大学加密服务器。研究者毕业后，电子数据将转移至加密移动硬盘（存放于导师办公室），保存5年。录像转录后立即删除，录音保留5年。期满后电子数据永久删除，纸质材料销毁。

### **自愿参与声明**

本人参与本项研究完全基于自愿原则，无任何强制义务。若决定参与，在论文定稿前（预计2026年4月）可随时退出研究或拒绝回答任何问题，且不会因此承担任何不利后果。如选择退出，研究者将立即删除此前收集的所有相关数据，并确保这些数据不会用于后续研究。

### **咨询渠道**

如对研究内容存在疑问，可联系研究者或其导师。

如对研究伦理规范存在疑问，请联系渥太华大学科研伦理办公室：

电子邮件：[ethics@uottawa.ca](mailto:ethics@uottawa.ca)

电话：613-562-5800 转 5387

### **注意事项**

建议保留本同意书副本作为个人记录。

**转录文本审核**

- 是, 我希望查看转录文本
- 否, 不需要查看

**参与确认**

- 同意参与
- 拒绝参与