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Original Research Article

Assessing the role of cross-cultural communication in shaping patient perceptions in medical tourism hospitals

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ABSTRACT

Background: Medical tourism has emerged as a key sector of the global healthcare industry, offering patients access to advanced treatments in foreign countries. While clinical outcomes are crucial, patient satisfaction is profoundly influenced by cross-cultural communication. This study investigates the impact of cultural competence on patient satisfaction in medical tourism, particularly focusing on communication styles and expectations.
Methods: A cross-sectional design was used to survey 1,476 international medical tourists in a government-approved healthcare facility in New Delhi, India. Data collection employed a detailed questionnaire encompassing six main sections, subdivided into 71 items covering verbal and non-verbal communication, cultural beliefs and time orientation. Statistical analyses included exploratory and confirmatory factor analysis, structural equation modelling and multi-group analysis.
Results: The findings revealed a significant positive relationship between patient beliefs in physicians' cultural competence and patient satisfaction. Intercultural communication expectations partially mediated this relationship. Operational factors such as waiting and consultation times emerged as moderators. The results indicated that providers who adapted communication styles to patients' cultural expectations achieved higher satisfaction rates.
Conclusions: This study highlights the importance of cultural competence in enhancing patient experiences and satisfaction in medical tourism. By addressing diverse cultural expectations and communication styles, healthcare providers can foster trust and improve outcomes. These findings underscore the need for systematic cross-cultural training as a strategic priority in the global medical tourism industry.

Keywords: Cultural competence, Hospital services, International healthcare, Medical tourism, Patient perceptions

INTRODUCTION

Medical tourism has emerged as a significant global industry, attracting millions of patients who travel internationally for various medical treatments. India, as one of the most prominent destinations, offers a competitive edge with its advanced healthcare facilities, highly skilled medical professionals and cost-effective treatments.[1] The ministry of tourism, government of india, reported that the country received 5.04 lakh medical tourists by October 2023, demonstrating the sector's rapid growth and global appeal.[2] However, despite these promising numbers, patient satisfaction and experience in medical tourism are shaped not only by clinical outcomes but also by healthcare providers' cultural competence.[3] In an industry that inherently bridges diverse cultural expectations, training healthcare providers in cultural sensitivity has become essential to foster positive patient experiences and outcomes. Effective intercultural communication is critical for building trust and ensuring patient satisfaction in medical tourism.[4] Healthcare providers often interact with patients from varied cultural backgrounds, each with distinct communication styles, expectations and healthcare beliefs. Research indicates that cultural insensitivity can lead to misunderstandings, patient dissatisfaction and

even non-compliance with medical advice.[5] For example, a study by Lee et al. found that patients who perceive their healthcare providers as culturally aware and respectful are more likely to follow medical instructions, resulting in better health outcomes. Miscommunication, on the other hand, was linked to a negative impact on patient experience and compliance.[6]

One primary area of focus in cross-cultural communication is understanding high-context and low-context communication styles. High-context cultures, common in Asian and Middle Eastern countries, depend heavily on implicit communication, context and non-verbal cues.[7] In contrast, low-context cultures, prevalent in Western countries, prioritize direct and explicit communication. This distinction significantly influences how healthcare providers interact with international patients. For instance, in high-context cultures, a blunt approach might seem disrespectful or offensive, while in low-context cultures, excessive indirectness may result in confusion and mistrust.[8]

Moreover, specific cultural norms, such as greeting styles, vary widely between countries. In conservative Muslim regions, physical contact between unrelated men and women is often minimized, whereas many non-conservative African cultures may embrace physical greetings like handshakes or hugs.[9] Understanding these cultural nuances helps healthcare providers navigate patient interactions with sensitivity, thus avoiding discomfort or misinterpretation.

Patients' cultural backgrounds often shape their healthcare beliefs, values and expectations, which can impact their satisfaction and adherence to medical guidance. Some cultures, for example, may emphasize holistic or traditional approaches to healthcare over modern, evidence-based practices.[10] In conservative Muslim societies, gender preferences also influence patient comfort, especially regarding clinical examinations by healthcare providers of the opposite sex.[11] These cultural preferences are less rigid in more liberal societies, where gender roles are more flexible.

Training healthcare providers to respect and accommodate these diverse perspectives can prevent discomfort and build a sense of trust and respect with patients.[11] For example, Gupta and Das found that culturally sensitive care improved patient satisfaction in Indian hospitals, reinforcing the importance of cultural competence as a fundamental aspect of quality healthcare in medical tourism.[13]

Globally, medical tourism has gained substantial research attention, with studies exploring patient motivations, economic impacts and quality of healthcare services.[14] In addition to India, countries like Thailand, Singapore, Mexico and the United States are prominent players in this industry, each with unique strengths and challenges. While some regions emphasize cost savings and high-quality care, recent studies have also highlighted cultural competence as an increasingly important factor in patient satisfaction.[15]

Studies show that communication barriers are a common source of dissatisfaction for medical tourists. Beach et al. underscore the necessity of cultural competence training for healthcare providers to address these communication gaps.[16] In contrast to intracultural communication—between healthcare providers and patients of the same cultural background intercultural communication presents a higher potential for misunderstandings, dissatisfaction and even patient opt-outs.[17] Intercultural communication thus becomes a critical area to address to maintain high patient satisfaction and positive healthcare outcomes.

In response to the growing need for culturally sensitive healthcare, medical institutions in India and beyond have started implementing cross-cultural training programs. These programs aim to improve healthcare providers' understanding of and respect for diverse cultural backgrounds, fostering a more inclusive healthcare environment.[18] Components of these programs include cultural awareness, sensitivity in clinical practices and strategies for effective communication.[19] Studies indicate that such training can significantly enhance patient satisfaction and healthcare outcomes in medical tourism, creating a competitive advantage for hospitals that prioritize cultural competence.[20]

For instance, Singh and Singh highlight that hospitals designated for medical tourism in India are increasingly adopting these training initiatives to enhance service quality.[21] Mukherjee further emphasizes the need for ongoing training and continuous professional development, ensuring that healthcare providers remain well-prepared to engage with culturally diverse patients.[20]

The growth of international medical tourism underscores the importance of cultural competence as a foundational element in patient care. As medical tourism continues to expand, healthcare providers in popular destinations such as India must adopt culturally sensitive practices to ensure a positive patient experience. Research consistently shows that effective cross-cultural communication and sensitivity can improve patient trust, satisfaction and adherence to medical advice, driving positive healthcare outcomes.[13]

The integration of cultural competence training within healthcare institutions is not merely an added benefit but an essential component of quality care in medical tourism. With countries like India making strides toward promoting culturally sensitive healthcare, the potential for sustainable growth in the global medical tourism market remains strong. As the industry evolves, culturally competent care will likely become a hallmark of high-quality medical tourism, strengthening patient-provider relationships and setting new standards for healthcare excellence on a global scale.

Theoretical framework and hypotheses

This study, grounded in post-positivism, explores how patient beliefs and expectations influence clinical experiences in intercultural clinical settings. We posit that unmet expectations, even when not leading to patient opt-outs, may diminish the quality of patient experiences, potentially resulting in dissatisfaction and negative word-of-mouth.

Theoretical framework

The study draws on Giles' (1994) communication accommodation theory (CAT) as its theoretical foundation23. CAT suggests that, in intercultural healthcare contexts, physicians who adapt their communication styles to align with medical tourists' cultural expectations are employing a convergent communication style. In contrast, those who prioritize professional authority or strictly adhere to local medical protocols utilize a divergent communication style. These communication strategies may significantly influence patient perceptions and satisfaction during medical tourism encounters.

Hypotheses

To test this framework, we propose the following hypotheses.

H1

Western and non-western medical tourists differ in their intercultural communication (ICC) expectations and experiences at the destination hospital.

H2

Physicians in the host country accommodate medical tourists using both verbal and nonverbal communication strategies, enhancing intercultural understanding.

H3

Positive beliefs about intercultural communication among medical tourists are associated with higher satisfaction in their intercultural clinical experiences.

The proposed model also considers control variables, such as patient age, gender and geographic origin, as well as moderating variables like waiting and consultation times, to account for their potential influence on patient experiences.

METHODS

Research approach

This study employed a cross-sectional research design using a convenience sampling technique to select participants. The final sample size included 1,476 international patients, providing a diverse range of perspectives on intercultural communication in healthcare settings.

Inclusion criteria

Inclusion criteria included patients willing to participate in the study and Patients willing to undergo treatment at the selected hospital. Exclusion criteria included patients not willing to undergo treatment or Patients unwilling to participate in the study.

Data collection

Data collection was conducted through a detailed questionnaire, developed in consultation with language translators to ensure clarity and cultural relevance across diverse patient backgrounds. The questionnaire employed a 1 to 10 scale, allowing participants to express nuanced assessments of their experiences. It comprised six main questions, further subdivided into 71 items, addressing critical aspects such as the quality of verbal and non-verbal communication, language barriers, body language, cultural beliefs and expectations, time orientation and high-context versus low-context communication. These constructs aimed to capture a comprehensive view of patient perceptions of intercultural interactions in healthcare.

Study context and participant demographics

Data collection took place at a NABH-accredited, Government of India-approved healthcare institution in New Delhi. The participants, who represented 34 different countries, were primarily medical tourists seeking treatment in India. This diversity provided a well-rounded perspective on the intercultural challenges and accommodations encountered in healthcare settings.

Data collection was conducted between April 2022 and November 2023 at AHI and Hospital, a multi-speciality hospital approved by the Government of India, NABH and JCI. Ethical approval for the study was obtained from the appropriate institutional ethics committee prior to commencement.

Data analysis

Data analysis was conducted using SPSSv24 for exploratory factor analysis (EFA) and Smart PLSv4 for confirmatory factor analysis (CFA), structural equation modelling (SEM) and multi-group analysis (MGA-PLS). The EFA identified three primary constructs intercultural communication (ICC) beliefs of patients regarding treatment in India, ICC expectations from Indian physicians and actual ICC experiences with physicians at the hospital. Harman's single-factor test was used to assess common method variance (CMV), which revealed a total variance of 32.78%, indicating acceptable CMV

levels. Confirmatory factor analysis in Smart PLSv4 refined the factors to three, supporting the model's robustness. Additionally, MGA-PLS analysis examined control variables such as age, gender and type of surgery, along with moderators such as waiting and consultation times (in minutes), to assess their influence on patient experiences.

RESULTS

The study's findings reveal significant insights into the intercultural communication (ICC) experiences of medical tourists in India, particularly in how patient beliefs, expectations and actual experiences align within an intercultural clinical setting.

Table 1: Demographic profile of the patients.

Demographic profile		N
Gender (1=male, 2=female)	1.00	832
	2.00	642
Geography non-western=2/1=Western	1.00	89
	2.00	1385
World Bank classification of economy (low=1, lower middle=2, upper middle=3, high=4)	1.00	1003
	2.00	347
	3.00	124
Grade of surgery	2.00	473
	3.00	589
	4.00	412
First Language	Arabic	4
	Arabic	295
	Bangla	19
	Bengali	17
	Bangla	7
	Dari	74
	English	203
	French	52
	Igbo	145
	Japanese	6
	Kazakh	7
	Kiswahili	280
	Kyrgyz	2
	Luganda	12
	Malay	3
	Mauritia	8
	Nepali	76
	Oromo	22
	Persian	6
	Russian	84
	Shona	83
	Turkish	9
	Ukrainian	13
	Uzbek	13
	Yoruba	25
	Zambian	9
Average waiting time with doctor (in mins.) (0-5=1, 6-10=2, 11-15=3, 15-30=4)	1.00	403
	2.00	510
	3.00	427
	4.00	134
Did you requested for more consultation time or second opinion in the hospital before taking decision to opt for this hospital. (yes=1, No=2)	1.00	1032
	2.00	442
Opted for medical treatment in this hospital (yes=1, no=2)	1.00	1391
	2.00	83

Continued.

Demographic profile		N
Duration of treatment (in months) (<3 months=1, 3-8 months=2, >8 months=3)	1.00	1270
	2.00	177
	3.00	27

Descriptive statistics and normality

Descriptive statistics, including measures of central tendency (mean and median) and dispersion (standard deviation), indicated that the data followed a normal distribution. Skewness and kurtosis values were within acceptable ranges, supporting the assumption of normality. This distribution allowed for more accurate application of structural equation modelling (SEM) techniques to examine relationships between constructs.

Key constructs and their measurement

Two key constructs were central to this study: Patient Beliefs and Patient Experiences with intercultural communication.

Patient beliefs (labelled "cognitive intercultural belief set") comprised items that measured confidence in Indian physicians' cultural awareness and intercultural competence, including familiarity with cultural differences, experience with intercultural patients and sensitivity to gender preferences. Patient Experiences (labelled "Behavioural Intercultural Experience") included items assessing the patients' actual experiences during their interactions with healthcare providers. This included elements like access to a language translator, the physician's communication style, culturally sensitive physical examination and advice on culturally appropriate health behaviours.

The confirmatory factor analysis (CFA) demonstrated that the indicators loaded strongly on their respective constructs, indicating high convergent validity. A significant path coefficient of 0.809 between patient beliefs and experiences highlighted a robust positive relationship; patients who held higher confidence in Indian physicians' cultural competence reported better overall experiences.

Structural model analysis

The path coefficient results provided support for the hypothesized relationships.

Patient beliefs to patient experience

The path coefficient between patient beliefs and the behavioural intercultural communication (ICC) experiences of patients was 0.604, indicating a substantial positive influence of patient beliefs on their experience in intercultural encounters.

The R-square value for the experience of patients (behavioural ICC) was 0.364, suggesting that 36.4% of the variance in patient experiences could be explained by their beliefs regarding the physicians' intercultural competence.

Patient expectations and patient experience

Patient expectations acted as a partial mediator between beliefs and experiences. The addition of this mediating construct led to a decrease in the direct influence of patient beliefs on experiences, signifying partial mediation.

This finding suggests that while beliefs impact experiences directly, the alignment of patient expectations also plays a critical role in shaping overall patient satisfaction.

Table 2: Path coefficient and outer loadings of the study.

	Experience of patients-behavioural CQ	Self-efficacy -Indian hospitals as MT hub
Experience of patients-behavioral CQ		
Self-efficacy -Indian hospitals as MT hub	0.604	
		Outer loadings
Actualexperfac1-3<- experience of patients-behavioural CQ		1
Awareofmycul <- self efficacy -Indian hospitals as MT hub		0.821
Culdisparities <- self efficacy -Indian hospitals as MT hub		0.731
Docscrossculexperience <- self efficacy -Indian hospitals as MT hub		0.821
Docsgender <- self efficacy -Indian hospitals as MT hub		0.81

Table 3: Descriptive, covariance and composite reliability analysis of the study.

	Mean	Median	Obs min	Obs max	SD	Excess kurtosis	Skewness	Number of observations used	Cramér-von Mises test statistic	Cramér-von Mises p value
Experience of patients	0	0.002	-2.474	3.7	1	0.79	0.261	1474	0.385	0
Self-efficacy	0	0.104	-2.303	3.388	1	0.73	0.135	1474	3.053	0

Covariances	**Experience of patients-behavioral CQ**	**Self efficacy -Indian hospitals as mt hub**
Experience of patients-behavioral CQ	1	0.604
Self efficacy-indian hospitals as MT hub	0.604	1

R-square	**R-square**	**R-square adjusted**
Experience of patients-behavioral CQ	0.364	0.364

f-square	**f-square**
Self efficacy -Indian hospitals as MT hub->experience of patients-behavioral CQ	0.573

Composite reliability	**Cronbach's alpha**	**Composite reliability (rho_a)**	**Composite reliability (rho_c)**	**Average variance extracted (AVE)**
Self-efficacy-Indian hospitals as MT hub	0.809	0.823	0.874	0.635

Reliability and validity

The reliability and validity of the constructs were assessed using Cronbach's alpha, composite reliability and Average Variance Extracted (AVE). For patient beliefs, Cronbach's alpha was 0.809 and composite reliability (rho_c) was 0.874, indicating good internal consistency.

The AVE of 0.635 met the threshold for convergent validity, affirming that the constructs captured a significant portion of the variance. Discriminant validity, assessed through the Heterotrait-Monotrait (HTMT) ratio, was 0.659 for the relationship between patient beliefs and experiences, confirming an acceptable level of distinctiveness between constructs.

Model fit and predictive relevance

The model fit indices supported the robustness of the structural model. The Standardized Root Mean Square Residual (SRMR) was 0.08, indicating an acceptable model fit and the Normed Fit Index (NFI) was 0.885, suggesting a good fit. Additionally, predictive relevance was studied using R-square values, with Experience of Patients - Behavioral Cultural Quotient (CQ) having an R-square value of 0.380 and International Patient Expectations with an R-square of 0.191, showing that these constructs explained substantial variance in the model.

Bootstrapping analysis

Bootstrapping analysis provided further support for the hypothesized relationships. The relationship between international patient expectations and experience of patients-behavioural CQ yielded a path coefficient of 0.154 ($t=5.963$, $p<0.01$), while the path between patient beliefs and experience of patients-behavioural CQ showed a coefficient of 0.534 ($t=27.046$, $p<0.01$).

These results underscore the significant impact of patient beliefs and expectations on their intercultural communication experiences, confirming the importance of these constructs in shaping overall satisfaction.

Blindfolding and predictive power

The predictive relevance of the model was further evaluated using the Q^2 value obtained through the blindfolding procedure. The positive Q^2 value of 0.36 for the experience of patients indicated that the model's prediction error was lower than the mean benchmark, suggesting that the PLS-SEM model provides better predictive performance than a simple mean-based model. Additionally, comparisons with a linear regression model (LM) revealed that the PLS-SEM results offered lower prediction errors (RMSE=0.801, MAE=0.659) compared to the LM approach, confirming the model's predictive efficacy.

A positive Q2 predict value indicates that the PLS path model's prediction error is smaller than the prediction error given by the (most) naïve benchmark.

Moderation and control variables

The study also examined control variables (such as age, gender, geography) and moderators (like waiting time and consultation time) to assess their influence on the main relationships:

Geography (Western vs. Non-Western origin) had a minimal effect, with a path coefficient close to zero (-0.003), suggesting that geographic origin did not significantly alter the impact of beliefs on experiences.

Consultation time and waiting time emerged as notable moderators. For example, adequate waiting times were positively associated with patient experience (path coefficient=0.203, f-square=0.027), suggesting that patients who experienced reasonable waiting times had better overall experiences.

Gender also showed a minor effect (path coefficient=0.097), indicating slight variations in experience based on gender. These findings suggest that while some demographic factors may have a minimal influence, factors like waiting and consultation time can significantly moderate patient satisfaction in intercultural clinical encounters.

Overall, the study's findings highlight the importance of patient beliefs and expectations in shaping intercultural communication experiences in healthcare settings. Patients who perceive Indian physicians as culturally competent are more likely to have positive experiences, particularly when their expectations are met.

Moreover, practical considerations such as waiting and consultation times play a role in moderating these experiences, underscoring the need for healthcare institutions to prioritize both cultural competence and operational efficiency in delivering patient-centred care for medical tourists.

Table 4: Blindfolding results.

Constructs	Original sample (O)	Sample mean (M)	Standard deviation (STDEV)	T statistics (O/STDEV)	P values
International patient expectations -> experience of patients-behavioral CQ	0.154	0.154	0.026	5.963	0
Patient beliefs -Indian hospitals as mt hub -> experience of patients-behavioral CQ	0.534	0.534	0.02	27.046	0
Patient beliefs-Indian hospitals as mt hub -> international patient expectations	0.437	0.438	0.026	16.623	0
	Q^2predict	**PLS-SEM_RMSE**	**PLS-SEM_MAE**	**LM_RMSE**	**LM_MAE**
MT patient experience	0.36	0.801	0.659	0.788	0.645

A positive Q2 predict value indicates that the PLS path model's prediction error is smaller than the prediction error given by the (most) naïve benchmark

Table 5: Lv prediction summary.

	Q^2predict	RMSE	MAE
Experience of patients-behavioral CQ	0.36	0.801	0.659
International patient expectations	0.189	0.902	0.702

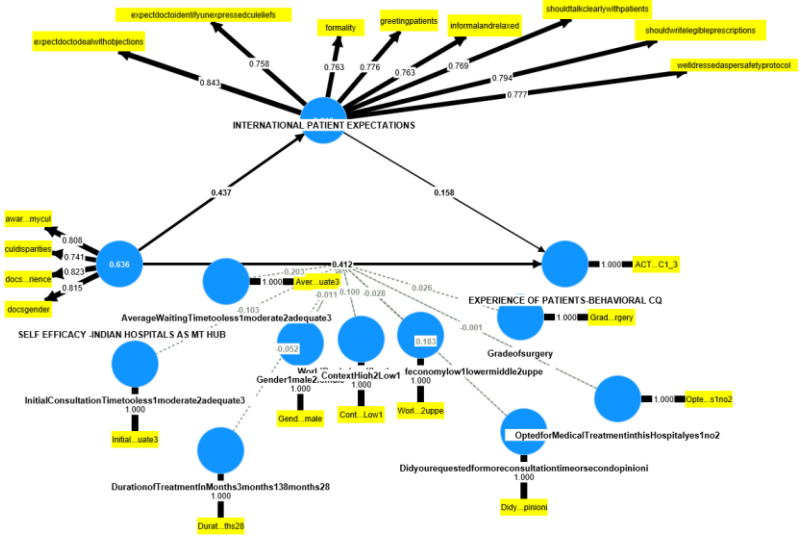

Figure 1: Study of moderating effect of the variables.

DISCUSSION

This study's findings provide valuable insights into the role of intercultural communication in shaping patient satisfaction in international medical tourism, emphasizing the importance of healthcare providers' cross-cultural competence. As the medical tourism industry grows, especially in countries like India, cultural competence among healthcare providers becomes a critical determinant of patient experience, satisfaction and, ultimately, the success of the medical tourism sector. The results of this study align with existing literature, reinforcing the need for healthcare institutions to foster cross-cultural competence in their staff as a strategy to enhance patient satisfaction and promote the country as a destination for medical tourism.

Cross-cultural competence in healthcare refers to the ability of providers to deliver effective services to patients from diverse cultural backgrounds, accommodating their unique beliefs, values and expectations. This competence is particularly vital in medical tourism, where patients often travel from different cultural and linguistic backgrounds, creating potential barriers to effective communication.[24] The strong positive relationship found between patient beliefs regarding physicians' cultural competence and their overall satisfaction underscores the critical role of cross-cultural skills in healthcare delivery. Patients who believe that their healthcare providers are knowledgeable and respectful of cultural differences are more likely to report positive clinical experiences. This finding is consistent with recent studies that highlight cultural competence as a key factor influencing patient outcomes and satisfaction in diverse healthcare settings.[25]

The Communication Accommodation Theory (CAT) by Giles (1994) serves as a useful framework for understanding these interactions, suggesting that healthcare providers who adapt their communication to meet cultural expectations (convergent communication) are more successful in creating positive patient experiences than those who maintain a rigid, protocol-driven approach (divergent communication).[23] Convergent communication, characterized by attentiveness to language preferences, non-verbal cues and cultural beliefs, helps bridge gaps and foster trust between healthcare providers and patients. Given that trust is foundational to effective healthcare, the study supports the notion that healthcare providers must develop competencies in cultural accommodation to improve patient satisfaction, a finding echoed by Almutairi et al, who emphasize the positive impact of cultural sensitivity on patient trust.[4]

Patient satisfaction is a multifaceted outcome influenced by factors such as clinical quality, communication effectiveness and cultural alignment between providers and patients.[26] In this study, patient satisfaction was significantly associated with both cultural beliefs and the meeting of expectations, suggesting that patient perceptions of provider competence in handling intercultural encounters directly influence their experience. This is particularly relevant in medical tourism, where cultural and communication barriers can heighten patient vulnerability and reduce satisfaction if not properly managed. Lee et al, argue that cultural sensitivity enhances patient satisfaction by addressing specific cultural and linguistic needs, which is crucial in building trust and ensuring that patients feel valued and respected.[19]

Our findings further highlight that meeting patient expectations is a partial mediator in the relationship between cultural competence beliefs and patient experiences, reinforcing the importance of aligning provider behaviours with patient expectations. In contexts where patients expect culturally appropriate greetings, sensitivity to language barriers and culturally tailored health advice, healthcare providers' ability to fulfil these expectations can significantly enhance satisfaction. This observation aligns with Heung et al, who found that patients' expectations of culturally appropriate care are a strong predictor of satisfaction in international healthcare settings.[17] Addressing these expectations requires healthcare providers to be proactive in understanding the cultural norms and preferences of diverse patient populations, which may vary substantially across regions.

Medical tourism relies heavily on the satisfaction and positive word-of-mouth (WoM) of international patients, as their experiences often shape the reputation of healthcare destinations.[9] The significant relationship between cultural competence and patient satisfaction in this study suggests that enhancing cross-cultural competence among healthcare providers is not only essential for improving patient experiences but also a strategic asset in promoting medical tourism. Positive patient experiences, driven by culturally sensitive care, can generate favourable reviews and recommendations, which are vital in attracting new patients from international markets.[3] This aligns with findings by Goel and Goel, who suggest that culturally competent care fosters loyalty and positive word of mouth, positioning medical tourism destinations more favourably in the global market.[11]

Countries like India, which have positioned themselves as affordable and high-quality medical tourism hubs, must recognize that competitive pricing and advanced medical technology alone may not be sufficient to attract and retain international patients. Cultural competence is increasingly recognized as a competitive differentiator in this market. Gupta and Das highlight that medical tourist value culturally sensitive care almost as much as clinical quality, particularly in countries where cultural and language differences are pronounced.[13] By implementing cross-cultural training programs, healthcare institutions can equip providers with the skills necessary to navigate diverse cultural expectations, thus enhancing patient

satisfaction and strengthening the reputation of the medical tourism industry.

Our study also found that operational factors like waiting time and consultation time influenced patient experiences, acting as moderators in the intercultural communication model. This suggests that in addition to cross-cultural competence, logistical aspects of care delivery are important for creating positive experiences. International patients, often limited by time and constrained by unfamiliarity with local systems, expect efficiency and responsiveness in healthcare settings.[34] Addressing these expectations not only improves satisfaction but also reduces the likelihood of negative word of mouth, which can harm a destination's reputation in the competitive medical tourism market.

The findings of this study have important recommendations for healthcare policy and practice, particularly for countries seeking to expand their medical tourism industries. Governments and healthcare institutions should consider investing in cross-cultural competence training as part of standard medical education and professional development programs. Such training should include modules on cultural awareness, sensitivity to verbal and non-verbal cues and skills for managing language barriers, which are crucial in addressing the diverse needs of international patients. Studies have shown that healthcare providers who receive cultural competence training are better equipped to handle intercultural encounters, leading to higher levels of patient satisfaction and loyalty.[27]

Furthermore, healthcare institutions should implement patient-centred policies that prioritize cultural competence alongside clinical quality and operational efficiency. This could include hiring multilingual staff, providing language translation services and designing care protocols that respect diverse cultural preferences. For instance, Singh and Singh highlight the success of Indian hospitals that have adopted patient-centred approaches by incorporating cultural sensitivity as a core component of service delivery.[22] These efforts not only improve patient satisfaction but also contribute to the broader goal of positioning India as a leading destination for medical tourism.

This study reinforces the importance of cross-cultural competence in enhancing patient satisfaction within the medical tourism sector. Patients' beliefs about healthcare providers' cultural competence and the alignment of provider behaviours with patient expectations were found to be significant determinants of satisfaction. These findings underscore the need for healthcare providers to develop intercultural communication skills and for healthcare institutions to incorporate cultural competence as a strategic priority. By doing so, countries like India can better position themselves in the global medical tourism market, attracting international patients who seek culturally sensitive and high-quality care. As medical tourism continues to grow, the role of cross-cultural competence will likely become even more critical, not only in enhancing patient experiences but also in driving sustainable growth for the medical tourism industry.

This study has certain limitations that should be acknowledged. First, the research was conducted within a single geographic location, focusing on a healthcare facility in New Delhi, India. This limits the generalizability of the findings to other regions and healthcare systems.

Second, the study relied on self-reported data from patients regarding their perceptions of cultural competence. Self-reported data can be subject to response bias, where participants may not always provide entirely accurate responses.

Another limitation is the cross-sectional design of the study, which provides a snapshot of patient experiences but does not capture changes over time. Longitudinal studies could offer deeper insights into how patient satisfaction and perceptions of cultural competence evolve throughout the treatment journey, from initial consultation to post-treatment follow-up.

Moreover, this research primarily focused on patient satisfaction and did not examine clinical outcomes directly linked to cultural competence. Future research could explore whether culturally competent communication impacts not only patient satisfaction but also clinical outcomes such as adherence to treatment, recovery times and overall health improvements.

Finally, while this study examined cultural competence as a whole, future research could analyse specific components, such as language proficiency or sensitivity to religious practices, to identify which aspects have the most significant impact on patient satisfaction. This could help healthcare providers tailor their training programs more effectively to meet the nuanced needs of diverse patient populations in medical tourism.

CONCLUSION

The findings from this research highlight the critical role of cross-cultural communication in enhancing patient satisfaction in the healthcare sector, particularly for international medical tourists. As the medical tourism industry continues to expand, healthcare institutions must recognize that patient satisfaction is not solely determined by clinical outcomes but is also significantly influenced by culturally sensitive communication. Imparting cross-cultural communication training to healthcare providers can bridge the gap between patients' expectations and their experiences, fostering trust and improving overall satisfaction. Cross-cultural communication training equips healthcare providers with the skills needed to understand and respect diverse cultural values, beliefs and communication styles. By

adapting to the cultural preferences of international patients, providers can minimize misunderstandings, enhance rapport and make patients feel respected and understood.

Training programs should focus on key aspects such as sensitivity to non-verbal cues, language barriers, cultural beliefs about health and illness and specific preferences related to gender and privacy. Studies show that culturally competent providers are better at building trust, which is essential for effective healthcare delivery in diverse patient populations. For medical tourism destinations, promoting cross-cultural competence within healthcare facilities is a strategic advantage. Positive patient experiences can lead to favourable word-of-mouth, strengthening the destination's reputation and attracting more international patients. Governments and healthcare institutions should invest in regular training and professional development programs focused on cultural competence. This commitment to patient-centred, culturally sensitive care not only enhances patient satisfaction but also positions the destination more favourably in the competitive medical tourism market. By prioritizing cross-cultural communication, healthcare providers can help create a sustainable and inclusive medical tourism environment that caters effectively to the needs of global patients.

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