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Health-seeking, intercultural health communication, and health outcomes: An intersectional study of ethnic minorities' lived experiences

Dion Sik-Yee Leung | **Ben Hok-Bun Ku**

Department of Applied Social Sciences, The Hong Kong Polytechnic University, Kowloon, Hong Kong

Correspondence
Dion Sik-Yee Leung, Department of Applied Social Sciences, The Hong Kong Polytechnic University, 11 Yuk Choi Road, Hung Hom, Kowloon, Hong Kong.
Email: dion.sy.leung@connect.polyu.hk

Abstract

Aims: To explore ethnic minorities' lived experiences of health-seeking and healthcare utilization in Hong Kong, and to examine the impact of intersectionality of sociocultural identities on intercultural health communication.

Design: Qualitative exploratory design.

Methods: Data collection methods were semi-structured interviews, unstructured observations, and unstructured informal group discussions. Twenty-five informants, including eight Pakistanis, seven Nepalese, five Indians, four Bangladeshis and one Sri Lankan, were recruited using the snowball sampling method and individually interviewed between 25th June and 23rd September 2019.

Results: Sixteen females and nine males, aged 21–76 years, were in the study. Two-thirds could communicate in English, but eight required interpreters. Thematic analysis reveals four factors affecting intercultural health communication: healthcare professionals' cultural insensitivity, red-tapism and ethnic minorities' language improficiency and/or deficiency in medical knowledge. Health professionals' workplace stress and cultural insensitivity prompt ineffective intercultural communication, making ethnic minority patients feel disrespected despite having adopted the Hong Kong culture. The intersectionality of sociocultural identities plus health professionals' blocking behaviours results in health inequalities.

Conclusion: The unequal power relationship between health professionals and ethnic minority patients may lead to dehumanizing and depersonalized experiences for patients, as humanity is the heart and soul of medicine. Therefore, the government should raise healthcare providers' cultural sensitivity and diversity awareness, and offer ethno-specific care and more interpretation services.

Impact: The study addresses health inequalities among Hong Kong ethnic minority patients with different sociocultural identities. About the impact of ineffective intercultural health communication on health inclusion and health outcomes, policies and practices should ameliorate health professionals' cultural sensitivity, awareness of the unequal power relationship and respect for diversity.

Patient or Public Contribution: Referred by organizations serving ethnic minorities, the minority patients shared their lived experiences in health-seeking.

KEYWORDS
cultural sensitivity, health inequalities, intersectionality of sociocultural identities, nurse–patient communication, unequal power relationship

1 | INTRODUCTION

A recent systematic review has reported that people from racial/ethnic minority groups and low socioeconomic status are more vulnerable to COVID-19 (Khanijahani et al., 2021). Socioeconomic status is one of the primary contributors affecting people's access to health care and differences in health outcomes (Thompson, 2014). Ethnic minorities, undermined by various structural, cultural and socioeconomic barriers, such as a lack of financial resources, improficiency in the host country's language and cultural stigmatization, are directly and indirectly experiencing denied access to health information and healthcare services. Also, the host population was fuelled by cultural misunderstandings to blame ethnic minorities for being highly susceptible to communicable diseases and spreading them to the community (Siu, 2015). It is the government's responsibility, along with health professionals, to challenge such misinformation and health inequalities; and deliver culturally sensitive healthcare services to ethnic minorities. However, not only do the general public lack awareness and respect for cultural diversity (Ku, 2006), health professionals, on the other hand, lack training in cultural competence and diversity awareness (Nair & Adetayo, 2019). Prior research has highlighted that ineffective intercultural health communication may result in unequal access to health information and inadequate participation in health decisions among ethnic minorities (Lee et al., 2014). The current study uses Hong Kong as a case to examine the intersection of cultural identities and socioeconomic status of ethnic minorities in health inequalities, thereby gaining an insight into ethnic minorities' perceptions, feelings and lived experiences in intercultural health communication when seeking health information and utilizing health services.

Impact statement

- The study addresses health inequalities among Hong Kong ethnic minority patients with different sociocultural identities.
- About the impact of ineffective intercultural health communication on health inclusion and health outcomes, policies and practices should ameliorate health professionals' cultural sensitivity, awareness of the unequal power relationship and respect for diversity.
- To improve health professionals' knowledge, attitude, awareness and competency when interacting with ethnic minorities with multiple identities.
- Develop and provide a systematic and comprehensive sensitivity training for health professionals' to increase their norms-critical awareness and respect for diversity is needed.

2 | BACKGROUND

2.1 | Ethnic minorities in Hong Kong

According to the 2021 population census (Hong Kong Census and Statistics Department, 2022), 95.8% (n = 6,791,737) of the Hong Kong population were Chinese, and 4.3% (n = 301,344) self-identified as non-Chinese after excluding the foreign domestic helpers who were non-citizens in Hong Kong. Among the ethnic groups, 35.4% were south Asians, 22.5% white, 15.4% Southeast Asians, 6.3% East Asians and 22.5% reported having more than one ethnicity.

2.2 | The cultural beliefs in Hong Kong

Culture is the shared patterns of behaviours and interactions, such as religious beliefs, value systems, languages, and practices in daily life that are unique to a group. Among the South Asian ethnic minorities, some are Sikhs, Christians, Buddhists, non-believers or believers of other religions, but the majority are Muslims (n = 250,000) and Hindus (n = 100,000-strong) in 2022 (Home and Youth Affairs Bureau Home, 2022). The cultural practices of Sikhs, Muslims or Hindus, for example, wearing salwar suits, headscarves (*khimar*), Muslim women's traditional modest dresses (*hijab*); eating halal food; practising Muslim fasting and praying; devout Muslim men growing a beard; Sikhs covering their long hair with a turban, etc., distinguish them from the Hong Kong Chinese who wear western-style clothing and mainly enjoy Chinese cuisine that is less spicy. And there are few Chinese men with facial hair or beards. Besides, most South Asian ethnic minorities are not fluent in either Chinese or English. Or they speak English with what is perceived as inferior accents by the host society that is in favour of British- or American-accented English. However, many speak several dialects or languages, namely Urdu, Hindi, Punjabi, Bengali, Arabi, Pashto, Nepali, Tami, Sri Lankan, etc., of their home countries. Some research studies have shown their cultures and religions getting them into difficulties in employment, education, health-seeking and receiving social services (Ku et al., 2003; Ku et al., 2005; Ku, 2006; Yu, n.d.).

Hong Kong is a Chinese-dominant society, with the integration of Confucianism, Buddhism, and Daoism that play an important role in everyday life among the Hong Kong Chinese (Leung, 2022). Daoism promotes simplicity and being in harmony with nature, and has given the practice of simple living, vegetarianism, exercise and martial arts (Qigong and Tai Chi). Buddhism has influenced Chinese culture in other religions, philosophy and ethics, literature, arts,

language and architecture. It was the Buddhist monks starting hospital services in China. Buddhists view human existence as suffering. To be saved from the cycle of rebirth that brings endless suffering is to live a virtuous life and engage in spiritual practices; then one can reach the transcendent state of nirvana. Nonetheless, Confucianism remains the most important, as restated in the Legislative Council in 2017 (HKSAR, 2017); the Hong Kong Government regards Confucian teachings as the core values of Chinese society. Inherent in Confucianism are the teachings of humanity, filial piety, reverence for people with learning or in a position of authority, and behaving with propriety in any social situation. Today, Hong Kong continues to be a patriarchal society under the influence of Confucianism; therefore, the physician–patient relationship might skew towards medical paternalism. The official languages of Hong Kong are Chinese and English, and schools do not teach any language of ethnic minorities. Therefore, Gao and Gube (2020) have argued that the Chinese language learning policy is an assimilationist integration framework, creating a barrier for the advancement in education among ethnic minorities in Hong Kong. In addition to western medicine, the local Chinese use traditional Chinese medicine associated with the philosophy of Daoism. Faith healing is not prevalent among the Hong Kong Chinese as it is among the ethnic minorities with the Muslim faith. The cultural differences between the ethnic minority groups and the Chinese majority group have generated various issues of intercultural health communication in Hong Kong.

2.3 | Intercultural health communication

Intercultural health communication is 'the exchange of symbolic messages about health between and among people who are not similar culturally' (Oetzel, 2014, p. 734), which can enhance patient satisfaction, health compliance and positive health outcomes if only that is performed well. Hence, culturally competent practice is required among healthcare providers to reduce the cultural divide in the healthcare setting (Kodjo, 2009). It is evident that differences in health beliefs and cultural values between ethnic minorities and doctors affect physician–patient communication. Effective intercultural health communication can facilitate mutual understanding between health professionals and ethnic minority patients.

Several predictors of cultural-related communication problems are associated with cultural differences in the perceptions of health and illness, namely, cultural values, patients' preferences for doctor–patient relationships, community context and family and perceptual biases and assumptions (Paternotte et al., 2015). Research has shown that health communication affects ethnic minorities' health-seeking behaviour (Crabtree & Wong, 2013). As there is a lack of language-appropriate printed materials about local healthcare services and ways to access those services, no wonder ethnic minorities are unfamiliar with the healthcare delivery system. In general practitioners' offices and hospitals, interpreters are not always available, making it difficult, or even impossible, for ethnic minorities with language barriers to communicate with health professionals. However, the involvement of interpreters could be a dilemma as it could breach privacy and confidentiality in the process of health communication. The presence of an interpreter also means that their actual consultation time with health providers will be cut short when everything must be translated back and forth, leaving less time for patients to provide important medical information in detail within a limited timeframe. The limited translation or interpreting service in public hospitals and social services, along with offensive nuances, racist stereotyping, and prejudice against ethnic minorities, jeopardize the proper public and health services for them. So far, despite the significance of intercultural health communication, only a handful of studies have explored the impact of intercultural/cross-cultural communication on health-seeking behaviour among ethnic minorities (Maneze et al., 2015).

3 | THIS STUDY

3.1 | Aims

By exploring ethnic minorities' lived experiences of health-seeking in Hong Kong, this study offers an insight into ethnic minority patients' difficulties and challenges when seeking health information and services in Hong Kong.

3.2 | Design

It adopted a qualitative approach using individual in-depth interviews, unstructured observations and unstructured, informal group discussions with ethnic minorities from 25th June to 23rd September 2019.

3.3 | Participants

It is often suggested that a qualitative study requires in-depth interviews with 10 individuals at a minimum (Creswell, 2013). The present study adopted the snowball sampling approach in sampling because it was difficult to enlist ethnic minority informants in Hong Kong. To follow the theoretical sample size of a previous study in Hong Kong (Vandan et al., 2019), 25 ethnic minority informants from five South Asian countries were interviewed until it reached theoretical and conceptual saturation. In this study, the inclusion criteria are (a) Indian, Pakistani, Nepali, Bangladeshi or Sri Lankan by ancestry; (b) holders of Hong Kong identity; adults aged 18+ years; (c) male/female gender; (d) skilled/unskilled occupations; and (e) with/without English or Chinese language ability in each South Asian group. Moreover, the sociodemographic variables, such as age, sex, ethnicity, religion, marital status, family role, household composition, length of stay in Hong Kong, language abilities, education level, and occupational class, as well as monthly household income, were included in the interviews of study (Table 1) (All names are pseudonyms).

This study has the support of Dr A (an Indian medical doctor), the Equal Opportunities Commission of Hong Kong, the Pakistan

TABLE 1 Informants' profile.

Informant	Pseudonyms	Ethnicity	Religion	Gender	Age	Marital status	Years of stay in Hong Kong
1	Bushra	Pakistani	Muslim	F	41	Married	14
2	Farhan	Pakistani	Muslim	F	30	Divorced	20
3	Anik	Bangladeshi	Muslim	M	51	Married	25
4	Sneha	Indian	Sikh	F	34	Married	11
5	Gulbadan	Pakistani	Muslim	F	28	Married	2
6	Manish	Pakistani	Muslim	F	68	Married	14
7	Sharif	Pakistani	Muslim	M	74	Married	53
8	Amrita	Pakistani	Muslim	F	40	Widowed	16
9	Umar	Pakistani	Muslim	F	36	Married	36
10	Alisha	Nepali	Buddhist	F	40	Married	22
11	Chaha	Nepali	Buddhist	F	42	Married	10
12	Rafiq	Pakistani	Muslim	M	72	Married	13
13	Alina	Nepali	Buddhist	F	39	Married	10
14	Heena	Nepali	Buddhist	F	33	Married	7
15	Chantin	Nepali	Christian	F	34	Married	2
16	Mayra	Indian	NA	F	21	Single	21
17	Bilhana	Nepali	Hindu	F	30	Married	6
18	Sadiya	Bangladeshi	Muslim	F	44	Married	9
19	Yash	Indian	Hindu	M	42	Married	9
20	Sang	Nepali	Hindu	M	34	Married	2.5
21	Raj	Indian	Muslim	M	74	Married	53
22	Minhaj	Bangladeshi	Muslim	M	54	Married	30
23	Barsha	Bangladeshi	Muslim	F	49	Married	24
24	Lakma	Sri Lankan	Islam	M	75	Married	49
25	Taksh	Indian	Muslim	M	76	Married	53

Women's Association of Hong Kong, the Catholic Diocese of Hong Kong, the Diocesan Pastoral Centre for Workers, and the South Asians who were invited for research interviews.

3.4 | Data collection and data analysis

There were 14 open-ended questions in the interview guide, comprising six sections, that is, overview, need for healthcare, macro-structural/contextual factors, predisposing factors, enabling factors and concluding remarks. The sample interview questions include:

1. What is your perception of the government's policies and support to you in seeking healthcare services? And why do you think so?
2. What were your recent experiences of health-seeking in Hong Kong? When and where were they? And who were involved?
3. What would you do if you need to use healthcare services in Hong Kong? And why?
4. What are your cultural background and heritage, and how they affect your perception of traditional medicine, complementary and alternative medicine, self-help, self-medication, and transnational healthcare-seeking? And in what ways?
5. Do you have anything you want to highlight health-seeking problems among the ME groups?

Each individual interview lasted for about 90 min and was audio-recorded. Additionally, four unstructured observations of 90–120 min and five unstructured, informal group discussions of 60–120 min were conducted with participants about the study topic. Field notes from these observations and discussions have deepened our knowledge about the informants' feelings, emotions and lived experiences in health-seeking process.

The method of thematic data analysis was adopted. First, all the scripts were read through sentence by sentence to obtain an overall impression of the data. After identifying some sentences/phrases/words, NVivo 12 Pro was employed for storing the inductive codes of specific themes. Different nodes were created via NVivo. Finally, some child nodes were aggregated and rolled up into parent nodes, presenting an overall perspective and showing how they were logical and relevant to the research aim. After a side-by-side comparison, common themes were developed to capture the meanings of the informants' experiences. After reflecting on her personal clinical experience with ethnic minority patients, the first author read the text repeatedly and checked it against her reflective journals and

fieldnotes on in-depth interviews and unstructured observations and discussions. She moved dialectically from the parts to the whole experience back and forth, again and again, focusing on eliminating inner contradictions and reaching a sensible meaning.

3.5 | Ethical considerations

The current study was a non-clinical project collecting data via interviews with human participants who were mentally intact adults with no special needs. Written informed consent was obtained. Participation was voluntary, and informants had the right to withdraw without any penalty or consequences. Ethics approval was granted by the Ethics Committee of the relevant University.

3.6 | Validity and reliability/rigour

Four strategies are employed to ensure credibility in the research study, that is, reflexivity, member checking, peer debriefing and peer examination. Reflexivity is a critical review of the influence of the researchers' background, perceptions and interests on data collection and analysis. With that in mind, the author critically reflected on her prior knowledge, assumptions and stereotypical views related to ethnic minorities, as well as her past experiences working with them as a clinical nurse. Member checking is to get informants' feedback about the categories, themes and interpretations of findings to ensure accurate representations of their perceptions, feelings and experiences. When the authors got the data analysis done in late 2019, they could not involve informants again because of social instability at a critical moment. To overcome the above hindrance, the first author managed to have an extended session with them, that is, prolonged engagement with Dr A's wife and his family during the Chinese Lunar New Year (late January 2020), allowing her to critically review her study. The discussion was insightful and beneficial in interpreting the data. About peer debriefing and peer examination, the first author discussed the codes, categories and themes with the second author before reviewing and verifying the findings. Then, a process of triangulation was applied in this study, comparing the results from different methods of data collection or data sources for testing trustfulness. The first author cross-checked the findings with her observations and informal group chat with the informants to verify her understanding and interpretations of ethnic minority patients' health-seeking experiences in Hong Kong.

4 | FINDINGS

4.1 | Healthcare professionals' cultural insensitivity

The informants expressed having problems with intercultural communication due to healthcare professionals' cultural insensitivity and lacking awareness of their religious beliefs, cultural traditions and taboos. For instance, Umar, a 36-year-old female Muslim, at one of her doctor's visits, disapproved of her nurse for lacking cultural sensitivity when she simply called upon a stranger to interpret for her: *'The nurse doesn't have that sensibility, that why she is calling a stranger to come and interpret. You know, nurse should have that sensibility'*. A breach of intercultural healthcare communication also happened to Farhan, a 30-year-old female Muslim, when she expressed her wishes to see a female doctor, citing the religious and cultural rules that prohibited her from exposing her body to a male doctor. She thought her religious and cultural rights were violated by her nurse who rejected her request, which obviously showed the nurse did not understand and had no respect for her cultural and religious traditions. She attested:

> About a lady seeking a male doctor, she won't prefer it, right? So many of the clients, even though they are ill, they need to see the doctor, but because of this issue, they said it's better to stay at home rather than see the doctor because religious rights, cultural rights, they don't want their body to be examined by the male doctor.

Furthermore, informants discovered inconsistent policies among healthcare providers. Sadiya, a 44-year-old female Muslim, sometimes found the hospital might arrange a female doctor for females of the ethnic minority but not at another time. All that made my informants feel perplexed. Experiencing another kind of problem, Mayra, a 21-year-old female with no religious belief, criticized doctors in Hong Kong who give their patients a '*verdict*' without a meaningful doctor–patient discussion. She would rather discuss her medical problems with her doctor than '*just obey him*' or let him '*dismiss the concerns*'.

> I think it is not just Indian; it's just that from my experiences, they talked to you, they tried to figure out and they proposed things to you. In Hong Kong, the doctor will just tell you his verdict and that is it. They do not talk with you. And I just feel like I need to discuss my problem rather than just obey him.

From Mayra's standpoint, she perceived that Hong Kong doctors did not adopt two-way communication with their patients. She also opined that Indian doctors were willing to discuss their illnesses with patients before putting forth suggestions accordingly.

4.2 | Language barriers

Communication problem is another issue for ethnic minorities in health-seeking. Raj indicated that most informants encountered communication problems with local Chinese healthcare providers due to language barriers. However, ethnic minorities' improficiency in Chinese and English is only part of the problem, not to mention the local healthcare providers' language incompetency. Amrita, a 40-year-old female Muslim, described an incident when

the nurses of a public hospital were unable to communicate in English properly with ethnic minority patients who have an accent; the nurses laughed at them, and that made the patients feel inferior:

> She is saying that she has like… like the problems with the nurses because they don't know their languages, they cannot communicate with them, and, the nurses cannot communicate and they cannot understand their English whatever they speak, and then the nurses start to laugh at them, so this is kind of rude to them they feel inferior at that time.

Gulbadan, a 28-year-old Pakistani woman staying in Hong Kong for 2 years, also had a similar experience: *'Whenever I ask for help, to anybody, they could not understand my language, they are like this in the hospital, in the general outpatient clinic, most of the staff, they do not understand (our) English'*.

It would be *'a huge problem'* if ethnic minorities could not communicate with the local Chinese, particularly with health professionals, in either Chinese or English, according to Farhan. She is a 30-year-old Muslim Pakistani homemaker living in Hong Kong for 20 years. She considers it quite hard to manage wherever one goes, to school or hospital, or to do whatever:

> I think if you can speak English, you can communicate then you have no problem to access any information in Hong Kong. But if you are facing language barrier, then, it's a huge problem for you whenever you go, no matter, it's school, or no matter it's hospital or whatever. It's quite hard to manage.

4.3 | Deficiency in medical knowledge

Informants also revealed that their deficiency in medical knowledge had generated fear in them about hospitals, a place for the infirm and the dying, and where they would have communication barriers with healthcare professionals. Like Chantin, a 34-year-old Christian Nepalese housewife, mentioned that when ethnic minorities do not understand medical words and medical terms, they cannot communicate well with health professionals: *'some of the medical, uh, word we didn't understand, right? So, we can just communicate a little bit, but we don't know about that medical words and medical terms. We don't understand even so it is better that they have'*. Worse still, that could further hinder those unfamiliar with the Hong Kong healthcare system from acquiring services when in need.

Heena, a 33-year-old Buddhist, reported that some ethnic minorities are used to going straight to the public hospitals for any ailments, either mild or severe, since they do not know *'how to approach the general outpatient clinic'*. Hospitals in Hong Kong are mainly for medical emergency services and referrals from doctors. The inappropriate demand from ethnic minorities for emergency services undoubtedly strains the healthcare system and drives up its running cost, but that is not their intention, so much as an act of desperation. Sang made it clear in his interview: *'I don't want to go hospital again and again'*.

For some informants such as Sang, a 34-year-old male Hindu, the aversion to hospitals prevents them from seeking healthcare. He does not want to visit hospitals frequently, for he does not feel good seeing many sick people in the hospital and is afraid of seeing '*fractured legs*':

> 'Because I feel like, not feels good also go see many… like a patient. I don't feel good. … Not because of patient, not feel like to go in the hospital again and again, this one could be health, I mean to say… Afraid, yea… I see maybe some like some fractured legs, some like, some people I feel very sad also'.

4.4 | Red-tapism

The complicated medical system generates many hurdles for ethnic minorities with language and cultural barriers in health seeking. Taksh, a 76-year male Muslim, admitted that his life as an ethnic minority in Hong Kong is *'difficult because of a lot of red-tapism and this and that'*; for example, they experience inconsistent administrative arrangements in interpretation services. Many ethnic minorities think they cannot acquire medical interpretation because of red-tapism, even though such a service is available. Some informants also disclosed that health professionals are reluctant to arrange interpretation services for ethnic minority patients, which blocks their healthcare utilization. Other informants complained of having difficulty accessing hospital services due to a lack of clear instructions given by healthcare providers. According to Heena, the hospital staff should have provided them with instructions guiding them in the health-seeking process. And she described the hospital usually gives patients an information slip showing them where to go for treatment, yet there is no clear written instruction. Thus, she and ethnic minority patients get confused when navigating the healthcare system, and she recounted her experience:

> Normally when they go to the hospital, they would just give a slip and then just ask you to go to this floor. But there is no clear instructions given to them. So she is hoping that maybe the hospital staff could be more clear and giving instructions and it would have been better… she will get confused when she seeks the services.

Bilhana, a 30-year-old female Hindu, agreed that the information provided by the hospital to ethnic minority patients should be explicit service instructions because she still did not know where to seek appropriate health treatment for her skin rashes.

Informants felt helpless in the health-seeking process when getting no specific information or assistance to guide them through the process. Or they have a limited income that restricts their healthcare options or even deprives them of necessary treatments. At one time, Bilhana was in such a dilemma and did not know where to turn; she described her sentiment then: *'At that point of time I felt like, Oh, I was so helpless because you want to get treated, but you don't have a platform.'* Farhan also mentioned that she might think of going to the private sector because seeking treatments in government hospitals wastes too much of her time. She complained: *'If it's something very pain and severe then I might think of going to the private sector. Because government hospital they are taking a lot of time, right?'*

It is difficult enough for the local Chinese to overcome hurdles of red-tapism in the complex healthcare system, never mind ethnic minority patients with language barriers. Getting no interpretation services or explicit service instructions from clinics and hospitals, plus limited care options because of poor finance, could further erode their motivation to seek healthcare information and services in Hong Kong.

5 | DISCUSSION

5.1 | Identity and intercultural health communication

Studies have suggested the importance of recognizing the influence of people's identity on the process of encoding and decoding information and messages in intercultural health communication (Hortobágyi, 2009). Of the 25 informants in the current study, 14 are Muslims and eight are females. Five key Islamic beliefs about values and practices form the identity of Muslim believers, that is, charity, daily prayer, confession of the Islamic faith, fasting during the month of Ramadan, and the pilgrimage to Mecca. Religion is one of the vital components forming a devout individual's self-identity, which endows believers with a distinctive sacred worldview quite different from that of secular non-believers. They turn to their god or gods for solace and solutions in stressful times. That said, waiting for the possible effects of faith healing may delay believers' health-seeking intentions. In the study, Muslim informants' religious identity influences their perception of health, diseases, and cures. Some religious practices, such as Ramadan fasting and the pilgrimage to Mecca, may expose them to health risks (Padela & Zaidi, 2018).

A person's physical body or appearance exhibits normative values of the social body. It is also central to one's personal identity, power, social interaction and thus society at large. Alisha, a middle-aged Nepalese homemaker, perhaps feeling hurt by others' offensive attitudes towards her physical traits, had this to say, *'because of the skin colour, they discriminate us.'* The physical body and the clothes on it provide a window through which we see a cultural value that visually bears out the salient ideas, concepts and categories fundamental to a person's culture. As a symbol, clothes help define a person's social location and represent the most obvious symbolic boundary marker. It identifies a member of the community (Ku, 2006: 290–291). The overall appearance of an individual affects how he/she is perceived and treated in the context of everyday life. Umar, a 36-year-old Pakistani woman of Muslim faith, pointed out why and what set them apart from the local Chinese: wearing headscarves and traditional attires or the beard on the man's face. To a Muslim woman, donning a headscarf is a symbol of modesty and her devotion to faith, while a devout Muslim man keeps a beard to emulate the ways of the Prophet Muhammad who had a beard. Those are just some ways of presenting an individual's cultural and religious identity. Farhan, a younger Muslim, affirmed it as part of religiosity that '*some Muslims strictly follow the religion; they cover their whole body*'. To drape her body in a long dress is also to observe the code of modesty in Islam. She said her religion prohibits a woman from exposing her body to a male doctor. That is why Muslim women, in an effort to preserve their religious and cultural identity, feel rejected or disrespected for being refused to be seen by a female doctor for almost all medical consultations in government hospitals or clinics, let alone to be attended by a female doctor of the same faith. As far as ethno-specific care is concerned, that is non-existent in Hong Kong.

Not knowing the local culture sometimes brings about a clash of cultures that leads to misunderstanding. Moreover, the perception and interpretation of semantic meanings in the intercultural health communication between ethnic minorities and local Chinese health providers can be inaccurate when based on each's own cultural and religious beliefs without putting oneself in another's place. South Asians can therefore be misunderstood as being non-adherent to medical advice and their underuse of health services as being against Western medicine (Joshi, 2020). Misinterpretation of semantic meanings can have a negative effect on intercultural health communication and ethnic minority people's health-seeking behaviours (Padela & Zaidi, 2018). Furthermore, misunderstanding cultural cues may induce discrimination. Research has shown that Islamophobia is everywhere across the world. It breeds structural Islamophobic discrimination that becomes the cause for bringing upon Muslims health disparities and poor health outcomes, thus requiring attention in public health (Samari, 2016).

5.2 | Language and intercultural health communication

The Chinese language is spoken by 95% of residents in Hong Kong, but most ethnic minorities do not know Chinese, and some are not even proficient in English. As the health information is mostly in Chinese or English in Hong Kong, South Asians may experience difficulty in understanding it (Wong et al., 2022). The majority of informants complained of having problems communicating with healthcare providers. Some argue that immigrants, for their own sake and the

harmony of the host society, should learn the culture, language, and values of the dominant group to achieve cultural assimilation and integration into the host country. However, Taksh said he has lived in Hong Kong for 50 years, but his business community is completely different from the Chinese environment, making it difficult to learn the Chinese language and fully acculturate into Hong Kong society.

Given the pragmatic value of learning the host country's language, ethnic minorities are expected to communicate in Chinese and follow traditional values and local lifestyles to fully integrate into Hong Kong society. Unlike most Western countries requiring immigrants to achieve a certain level of proficiency in the host language, Hong Kong has no immigration and settlement policy, implying that the government does not make the effort to promote immigrant acculturation. Consequently, first-generation immigrants seem more inclined to keep their cultural identity and home language instead of learning the host language for full assimilation into Hong Kong.

Nonetheless, the Hong Kong government has been actively promoting the 'trilingual, biliterate' policy, enticing its residents to achieve proficiency in English, Cantonese and Putonghua. That has amounted to a surge in English proficiency in Hong Kong over the last 20 years. The use of language is associated with social power relations and the construction of cultural identity. So far, English still holds a higher status in Hong Kong, and its citizens consider the use of English as a part of their cultural identity. Those with a high level of English distinguish themselves from those with poor or no knowledge of English, getting better jobs and earning more. However, eight out of the 25 informants in this study use only their home language, indicating that non-English speaking ethnic minority groups may feel inadequate in constructing an identity as a Hongkonger if they do not share at least a common language with the locals. Their English improficiency may also submit them to discrimination when seeking healthcare services or applying for higher paid jobs. The interplay between culture and language has a significant impact on the effectiveness of doctor–patient communication (Woodward-Kron et al., 2011). Ethnic minority groups who cannot communicate in either English or Chinese with local health professionals may be further exposed to an unfavourable salience of their cultural identity, resulting in ineffective intercultural health communication. All that can impede their healthcare-seeking behaviours, making them reluctant to obtain healthcare services locally.

Even though the general proficiency in English has improved over the past two decades in Hong Kong, only about 6% of respondents in a recent study spoke English well, and about 1.5% spoke 'native-like' English. Almost all the staff in general outpatient clinics and hospitals are Chinese and have learned English in school but no other languages, which is why they could not understand ethnic minorities' mother tongues. Besides, they have trouble hearing English with foreign accents, especially those being improficient in English.

In brief, this study identifies problems on both sides in intercultural health communication: ethnic minorities lack proficiency in English and Chinese, while healthcare providers need to improve their English. If they cannot verbally communicate relatively well with ethnic minorities, they could at least not halt the communication suddenly, which likely put patients in distress. Rather, they could use an alternative way of communication by writing, gesturing, or asking another healthcare provider to assist the patient until a medical interpreter can be arranged. Alisha, a 40-year-old Nepalese housewife, recounted her experience with a nurse through an interpreter—whatever she said, the nurse would answer '*okay*' and then walk away. She was left there not knowing what to do and was overcome by a sense of helplessness. How healthcare providers treat ethnic minority patients can significantly impact their community's health-seeking behaviour, as many of them rely on word of mouth for information. Bilhana is one of them and she said: '*I would seek information from my, um, nearby friends or in the circle*'.

5.3 | Unequal power relationship and intercultural health communication

Foucault suggested that power is everywhere and comes from everywhere, constituted through knowledge and truth. As healthcare practitioners have received professional training in biomedical science and medical skills, they are endowed with power over patients, creating an unequal power relationship in intercultural health communication in their favour. Foucault also developed the concept of the 'medical gaze' (Foucault, 1994), stating that medical doctors select the biomedical aspects of patients' problems and modify their stories with a biomedical paradigm. That further engenders the doctor-oriented model in health communication. With ethnic minorities lacking influential political power, policymakers may not consider their mental health needs among the most important issues when it comes to setting policy priorities (Kwan & Lo, 2022).

Mayra, an informant in the current study, described doctors in Hong Kong giving patients just their verdicts in medical consultations without any room for discussion. She feels that doctors only want patients to obey rather than have a meaningful doctor–patient discussion. This reflects the medical system as a bureaucracy operating like an assembly line of a factory; its doctors, nurses, and other healthcare providers exercise their substantial discretion and power in decision-making for patients. Also, it can be interpreted as the undesirable outcome of medical paternalism: Hong Kong is a patriarchal society under the influence of Confucianism, patients have high respect for doctors as someone knowledgeable and in a respectable position, so they seldom question their medical decisions and trust doctors to give the '*verdict*' in the patients' interest. Such an act depicts an unequal power relationship in health communication when healthcare practitioners make patients surrender autonomy and independent thinking by taking up the sick role and obeying their verdicts. Our findings echo Tan et al.'s (2021) argument that healthcare providers' 'inattentive communication skills and paternalistic attitudes' discourage patients from involving in care-related decision-making.

Hong Kong has a long history of racial barriers as it was a British colony before 1997, ranking the white race superior above all coloured races; racial hierarchy has survived. Skin colour does matter to an individual; research suggests that the darker his/her skin, the greater the

prejudice and bias he/she may face, and the lower he/she is in the racial hierarchy (Kapai, 2015). Besides, the Chinese Nationality Law has denied ethnic minorities' cultivated sense of belonging to Hong Kong as it rejected them as Chinese citizens because of their lack of Chinese ancestral lineage and '*Chineseness*'. Ethnic minorities, voluntarily or involuntarily, have ended up as cultural outsiders caused by systematic marginalization. On top of that, British- or American-accented English is revered as the standard English in Hong Kong, whereas all other English variations, such as Indian English, are treated as inferior and weird (Gu et al., 2014). According to Foucault (Foucault, 2003), the norm is defined by the race that holds power, resulting in only Chinese and English being the official languages of Hong Kong. The marginalization of English variations based on the interlocutors' race devalues their identity and challenges their equal position in intercultural health communication. That was the reason informants of the current study felt that Chinese medical doctors dismissed their concerns, which illustrates the concept of intercultural health communication competence that ethnic minorities would never be recognized as competent English speakers regardless of their proficiency.

Furthermore, patients, particularly the ethnic minorities at the lower end of the racial hierarchy, may feel excluded from health decision-making at the cost of the so-called *'medical professionalism'*. Health practitioners carry out their work in keeping with professional knowledge and ethical codes, though aligning with professional and political correctness, their poor health communication skills may contribute to health disparities (Calderón & Beltrán, 2004). In fact, new immigrants, especially female immigrants, often possess little or no knowledge or skills to navigate the complex healthcare system in Hong Kong; as a result, they feel discouraged from accessing health services. Another communication problem that informants encountered with health professionals in this study, as some expressed frustration, is not knowing medical words and terms, which hinders patient–healthcare provider communication. This study reveals that health professionals' use of medical terms and professional jargon have made social differences between them and ethnic minority patients noticeable or even intimidating.

5.4 | Professional stress and intercultural health communication

The psychosocial work environment concerns the conditions of the job and work environments as follows, economic and sociopolitical structures, workplace structures, job demands and individuals' cognitive and emotional processes, all of which may induce workplace stress. In February 2019, a newspaper reported a protest staged by medical doctors and nurses. That was to highlight the grave and challenging problems in the health system in Hong Kong, that is, heavy workload, poor overtime pay, and overcrowded hospitals (Cheng, 2019). Since emotional labour is inherent to health professionals' call of duty, they must manage their feelings and emotions while caring for patients and in contact with their families, which can sometimes cause them emotional exhaustion, especially under heavy workloads. Nurses' workplace stress, burnout, and job satisfaction have a direct impact on their interpersonal relationships with patients (Utriainen & Kyngäs, 2009). Insufficient staffing in overcrowded hospitals and repeated requests from patients may trigger health professionals' negative emotions, making them fail in interpersonal communication. Busy health professionals communicating with patients in a rushed manner can negatively impact health communication, discouraging patients from seeking health care.

Healthcare providers' blocking behaviour can make them fail to respond to patients' concerns, and that can be viewed as a dehumanizing act towards their patients (Chinweuba et al., 2013). For example, Alisha, who could only speak Nepali, found the nurse walking away from her in the middle of her enquiry, it might not have been racial discrimination against her. Perhaps, it could be much to do with the nurse's blocking behaviour, a fight-or-flight response in action, that she wished to distance herself from a situation not in her control: having a fear of assisting ethnic minority patients. In his speech at Cornell College, Mount Vernon, Iowa, Martin Luther King rightly alerted us to it, on 15 October 1962, that *'people fail to get along because they fear each other'*. That, by extension, perhaps explains why there is always a separation *'between them and us'* among people of different races and ethnicities when their fear is borne out of having little or no knowledge of each other's cultures, values and worldviews. Even as remarked by Ludwig Wittgenstein about the talking lion, merely sharing a common language cannot enhance healthcare professionals' better understanding of ethnic minorities if they do not recognize and respect ethnic minorities' cultures, values, perceptions and experiences (Schouten et al., 2020).

One's ability to display cultural competence is directly related to their expressiveness, such as facial effects and vocabulary usage. Whether or not health professionals are competent in intercultural health communication, their performance is perceived and evaluated by none but others because competence is a social judgement. Most informants in the interviews commented on having poor intercultural health communication with health professionals. Nevertheless, intercultural health communication competence is a relational process, and the expectancies, norms, and rules of the relationship should not be violated significantly (Martin, 2015). Thus, health professionals should strengthen intercultural health communication competence by enhancing their resilience to cope with workplace stress and developing relational skills to maintain satisfying interpersonal relationships with patients from various cultural backgrounds. It is equally important that hospitals and the government develop a strategy to mitigate the negative impact of emotional labour among their doctors and nurses.

5.5 | Gender and intercultural health communication

In cross-culture health communication, health professionals heavily rely on ethnic minority women caring for the whole family's health. Therefore, women's capacities to understand health information and

materials will affect the family's health communication. The important source of health information for these women are family and friends, either in their home countries or Hong Kong. They also get it from the internet, general outpatient clinics and hospitals.

Although most female informants are expected to go to work and also help with household chores, according to Bilhana, a college-educated working mother, ethnic minority women are mostly responsible for seeking health information, making doctors' appointments and accompanying the sick for medical attention. Like busy health professionals, they are also fully engaged in many tasks and obligations concerning their families, suggesting that such social constraints prevent these busy ethnic minority women from having enough time to understand the complex medical system. That imposes not only negative impacts on their health communication skills, but also the health-seeking behaviour of themselves and their families.

In this study, we discover that ethnic minorities, especially women, have a psychological fear of going to hospitals and seeing patients sick with medical problems. Hospital anxiety or stress, is about the anxious response and unusual fear that a person feels from visiting hospitals or receiving medical care in a hospital (Pellosmaa & Desouky, 2013). The irrational fear, induced by an individual's cultural and religious beliefs, could drive people away from seeking health information and medical care and also cause them to disregard medical advice.

6 | IMPLICATIONS FOR NURSING

It is obvious that not many healthcare professionals understand the language of other ethnicities and the role of interpreters. When they invite their ethnic minority patients' relatives or friends to be interpreters, they may breach patient confidentiality and impact healthcare outcomes by using unqualified medical interpreters. Informants of the present study proposed that the government could employ some doctors or nurses with ethnic minority backgrounds, either Muslim or familiar with Islam and Islamic bioethics. This echoes a recent study suggesting that culturally compatible role models should be identified and trained to provide culturally sensitive information and services to ethnic minorities (Wong et al., 2022). That will reassure ethnic minority patients that their healthcare professionals can care for them properly because they understand their languages and cultures. Hong Kong is facing a shortage of nurses in the public health system while healthcare needs are growing along with the ageing population, and the suggestion could meet the health needs of ethnic minority patients.

An informant of the present study complained about nurses in a public hospital refusing to arrange an interpreter for her when they were unable to communicate with her in English. Therefore, culturally and linguistically appropriate health education should be developed and disseminated through various social media to enhance health awareness among minority ethnic groups (Wong et al., 2020). Although public hospitals provide interpretation services and make healthcare information materials available in 18 languages in public clinics and hospitals, ethnic minority patients may still feel socially excluded from the health system if hospital staff cannot develop cultural competence and respect cultural diversity. Despite an increase of interest and significance in cultural competence and diversity awareness training for healthcare professionals, diversity awareness training cannot be successful without a supportive work environment (Sanchez & Medkik, 2004), especially in Hong Kong where most residents are Chinese. Yet, regular cultural sensitivity training for healthcare professionals is still insufficient in Hong Kong (Vandan et al., 2020). To succeed in 'people-centred care' in a culturally diverse Hong Kong, healthcare providers should cultivate a multicultural friendly environment for ethnic minorities, making them feel secure and welcome while attempting to meet their health needs. This study provides insights into improving the psychosocial work environment for facilitating better communication between health professionals and ethnic minority patients in Hong Kong and the world. A systematic and comprehensive sensitivity training needs to be developed and provided for health professionals to increase their norms-critical awareness and respect for diversity.

7 | LIMITATIONS

Interviews with selected ethnic minority informants were conducted from June to September 2019 during a period of political instability in Hong Kong because of protests triggered by the Fugitive Offenders Ordinance. It was a challenge to arrange a safe time and place for interviews, which significantly affected the data collection process. The study was conducted before the COVID-19 pandemic so it did not explore the health disparities among ethnic groups during the outbreak in Hong Kong.

8 | CONCLUSION

This study has shown that ethnic minorities' health-seeking behaviour is a dynamic process of adaptation, with variations in the ethnic minority groups due to their different experiences in interaction with the structure, culture, and agency. However, ethnic minorities are not well respected, even though some have tried to adapt to Hong Kong culture. Apart from the lack of awareness and respect for cultural diversity among the Hong Kong population (Ku, 2006), the ethnic minority informants in the present study also criticized local Chinese healthcare providers' lack of cultural sensitivity and unfamiliarity with their cultural traditions and religious practices. Therefore, our findings suggest that it is essential to educate healthcare providers on intercultural health communication to better serve the diverse society of Hong Kong. Healthcare professionals should be culturally competent, making intercultural health communication effective and efficient when interacting with ethnic minority patients. This may combat discrimination and health disparity, which causes ethnic minority patients distress or even deter them from seeking healthcare services in the host country.

The unequal power relationship between health professionals and ethnic minority patients may lead to dehumanizing and depersonalized experiences for patients, as humanity is the heart and soul of medicine. Intercultural communication is essential for cross-cultural health care, as a misinterpretation of semantic meanings can adversely affect ethnic minorities' health-seeking behaviours and health outcomes. Evidence shows that minority ethnic groups have borne more COVID-19 pandemic's negative impacts than other groups partly because of cultural and socioeconomic differences (Abuelgasim et al., 2020). Therefore, our findings suggest that health professionals should learn to be culturally sensitive so that they become capable of identifying ethnic minority patients' problems in the communication process. If we become more culturally sensitive, we could deliver better care to ethnic minorities.

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The authors declare no conflicts of interest.

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ORCID

Dion Sik-Yee Leung https://orcid.org/0000-0001-8674-3638

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