

## Examining the Links Between Communication and Optimal Outcomes in Foreign Domestic Workers' Perceived Health-Care Experiences: An Analysis of Proximal and Intermediate Outcomes

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Filipina and Indonesian domestic workers constitute the largest ethnic minority group in Hong Kong. Yet, little empirical research has explored these foreign domestic workers' (FDWs') perceived health-care experiences when they work and live in Hong Kong. Invoking Street and colleagues' model of pathways linking communication to outcomes, this article aims to unpack how FDWs' communication with clinicians influences their perceived outcomes. Thirty domestic workers shared their experiences of using health-care services in Hong Kong and the subsequent outcomes. Their narratives were thematically analyzed. Results showed that 3 key themes related to proximal outcomes were important to FDWs with respect to their communication with clinicians. These were satisfaction with clinicians' communicative behaviors, trust in clinicians, and their knowledge acquisition. Two major intermediate outcomes resulted from their proximal outcomes and directly impacted FDWs' health and well-being. These were adherence to clinicians' instructions and acquisition of self-care skills. Future research directions and implications for health communication interventions are discussed.

*Keywords: foreign domestic workers, patient-clinician communication, health communication, health outcomes*

With a high standard of living and comparatively benevolent policies (Chan, 2006), Hong Kong has grown into a major labor-import city known for its large number of foreign domestic workers (FDWs). The number of FDWs employed in Hong Kong in 2021 was 339,451, with the majority arriving from the Philippines and Indonesia (Census and Statistics Department, 2022). Hong Kong families rely heavily on FDWs for housework, assistance with child-rearing, and elderly care (Kwan & Dunworth, 2016). Though it is undeniable that FDWs have contributed innumerable benefits to the Hong Kong economy, their significance has been understated by local society, resulting in them being frequently neglected when it comes to their health-care needs (Ladegaard, 2017; Lui et al., 2021). FDWs are typically exposed to adverse working and living environments (e.g., cramped living spaces and long working hours), increasing their risks of experiencing adverse health outcomes such as musculoskeletal injuries,

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depression, and various forms of abuse and exploitation (Berkman, Kawachi, & Theorell, 2014; Gao et al., 2014; Jolles, Richmond, & Thomas, 2019). Low socioeconomic status, lack of knowledge of their rights, and minimal social support can aggravate these female FDWs' existing vulnerabilities, hence negatively impacting their physical and psychological well-being (Fong & Yeoh, 2020; Gao et al., 2014). Compared with the general population in Hong Kong, FDWs often have a poorer health status (Chung & Mak, 2020) and they are a group that is especially in need of effective health-care treatment when they experience medical problems. Through its focus on female FDWs, a marginalized and under-researched population in Hong Kong, this study addresses a knowledge gap concerning minority groups' unique health-care experiences.

Health communication plays a critical role in raising public awareness about health, informing individuals about risk management, and motivating them to adhere to recommended procedures (Gebbers, de Wit, & Appel, 2017). Effective patient-clinician communication (PCC) is essential for establishing a successful therapeutic relationship (Street & de Haes, 2013), ensuring that patients engage in medical care and achieve optimal health-care outcomes. Communication between FDW patients and clinicians is one of the least researched areas concerned with FDWs' health care. Communication difficulties between patients and their clinicians may lead to misunderstandings and undesirable outcomes that can undermine their health status. Because of their lack of familiarity with Hong Kong health-care services as well as their fragility caused by their level of educational attainment and their linguistic and socioeconomic disadvantages, FDWs are likely to feel stigmatized or misunderstood by clinicians, which can adversely impact their treatment outcomes (Holroyd, Molassiotis, & Taylor-Pilliae, 2001; Woo et al., 2017). Because many FDWs live in poor conditions that can adversely affect their health, it is critical to investigate how communication affects their health outcomes. In particular, this research allows us to recognize the complexities of care delivered to ethnic minority populations who are susceptible to a variety of vulnerabilities (e.g., social isolation and linguistic barriers), pinpoints areas where communication can be improved, and ultimately facilitates the creation of interventions that enhance minority groups' health outcomes.

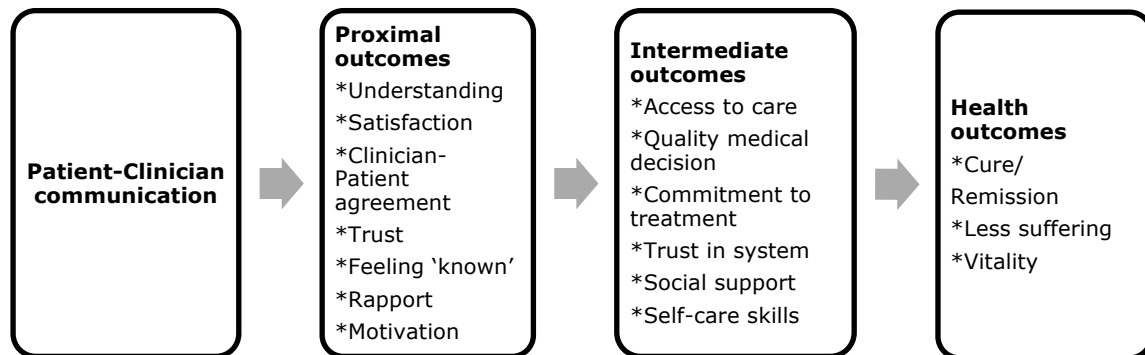
### ***Relationship Between Communication and Health Outcomes***

A review of previous research shows that there exists "null, inconsistent, or contradictory" (Street, 2013, p. 286) evidence as to the relationships between PCC and patient outcomes. Some studies have revealed a positive, strong correlation between PCC and health outcomes (e.g., Clark et al., 2008; Hoffstädt et al., 2020). Scholars have drawn the notion of patient-centered communication, defined as a set of communicative behaviors contributing to the improved quality of patient-clinician relationship (Stewart, 1995; Wanzer, Booth-Butterfield, & Gruber, 2004), and highlighted that patient-centered communication promotes patients' positive health outcomes (e.g., Levinson, Lesser, & Epstein, 2010; Street, Cox, Kallen, & Suarez-Almazor, 2012). For example, Robinson, Hoover, Venetis, Kearney, and Street (2013) captured interactions between female patients with breast cancer and surgeons by undertaking surveys and video recordings and concluded that patient-centered communication was fundamental in influencing these patients' satisfaction with surgeons, which subsequently affected their levels of post-consultation hopelessness. A similar result was found in a cross-sectional study, which indicated that patients experiencing patient-centered communication reported higher self-efficacy levels,

especially among patients with serious illness burdens (Finney Rutten et al., 2016). Yet, existing studies also demonstrate that PCC is not necessarily concerned with patients' health outcomes (e.g., Manser, 2009; Takeuchi et al., 2011). For example, in a retrospective study conducted among patients with diabetes, no evidence was found regarding the association between patients' involvement in shared decision making and their adherence to antidiabetic medication (Milky & Thomas, 2020). These inconsistent findings could be explained by the interplay of multiple contextual factors or moderators across studies, such as the duration of consultations and clinicians' sensitivity to patient characteristics, as well as a paucity of research regarding how communication influences health outcomes (In'nami, Koizumi, & Tomita, 2020; Jiang, 2017; Mead, Bower, & Hann, 2002; Zandbelt, Smets, Oort, Godfried, & de Haes, 2007). It is incumbent on researchers to tease out the relationships between PCC and health outcomes based on specific contexts. By assessing and understanding the pathways from PCC to FDW patients' ultimate outcomes, we can gain a better understanding of how various factors interact and impact the well-being of FDWs.

### ***Model of Pathways Linking Communication to Health Outcomes***

Street, Makoul, Arora, and Epstein (2009) argue that, although PCC can directly impact health outcomes, the process through which communication exerts such effects often follows an indirect or mediated path. In their proposed model of pathways from communication to health outcomes (Street et al., 2009; see Figure 1), proximal outcomes and intermediate outcomes play the mediating roles between communication and health outcomes. Proximal outcomes are often results that occur as an immediate result of communication (Jiang & Lam, 2021), including constructs such as patients' satisfaction with care, understanding of health information, trust in clinicians, motivation to comply with treatment, and clinician-patient agreement. A quantitative study conducted by Borah and Hwang (2022) found that doctor-patient communication was essential for increasing patients' trust in doctors (a construct of proximal outcome), thereby contributing to patients' positive attitudes and behaviors regarding H1N1 vaccination. Intermediate outcomes arise because of the effects of the proximal outcomes, which in turn affect the ultimate outcomes of health. Patients' access to care, social support, commitment to treatment plans, and self-care skills are examples of intermediate outcomes. For instance, establishing patient-clinician agreement (a construct of proximal outcome) regarding treatment plans may promote patients' adherence to medical treatments (a construct of intermediate outcome), which potentially contributes to patients' optimal health outcomes (Thompson & McCabe, 2012). There are no studies that focus on FDWs' reported health experiences with clinicians. However, Schinkel, Schouten, Kerpclik, Van Den Putte, and Van Weert (2019) applied the Street (2001) model to investigate the narratives of ethnic minority patients in the Netherlands. They found that interventions to raise the clinicians' awareness of their cultural differences with respect to communication barriers and differences in communication style were required to enable patients to actively engage and feel comfortable during the consultations (Schinkel et al., 2019).



**Figure 1. Examples of outcome-related factors extracted from Street and colleagues' (2009) pathway model.**

Street and colleagues' (2009) pathway model has been applied in the Western and Asian health-care contexts. In a study of Chinese patients, Jiang (2018) used the pathway model to explore the relationship between PCC and emotional health and found that PCC affected patients' emotional health indirectly, with uncertainty management skills being the mediator. However, studies invoking the pathway model (Street et al., 2009) have not closely examined minority patients' health-care experiences; nor has the pathway model been used to guide the analysis with qualitative modes of inquiry. This represents a serious gap in knowledge. Additionally, the question of how FDW patients perceive their communication with clinicians and its link to health outcomes has remained unanswered. Due to their legal status and ethnic identity, FDWs are often marginalized and vulnerable to poor health status, and their health-care experiences are rarely documented. Further research is needed to determine FDWs' beliefs and perceptions about how communication impacts their health outcomes so that effective strategies can be designed to assist FDWs in achieving desirable health outcomes. To fill the aforementioned research gaps, this study sought to use Street and colleagues' (2009) pathway model to explore the underlying mechanisms that connect PCC to health outcomes; Hong Kong FDWs' narratives were analyzed to gain an understanding of how communication influences their perceived health outcomes, helping elucidate the relationships among outcome-related elements. In light of the limited research regarding how PCC impacts FDWs' perceived health outcomes, hypotheses could not be formulated. Following the pathway model (Street et al., 2009), two research questions were addressed to examine FDWs' perceptions of communication with clinicians and subsequent outcomes:

*RQ1: What are the proximal outcomes that result directly from PCC?*

*RQ2: What are the intermediate outcomes that impact FDWs' perceived ultimate outcomes?*

## Method

### Research Design

FDW patients' narratives regarding their communication with clinicians and subsequent outcomes were investigated by using semi-structured interviews. Ethical approval was sought from our affiliated

institution (HSEARS20191222001; HSEARS20200917003). The whole project was carried out between April and September 2019 and between September and December 2020.

### ***Participant Recruitment***

Snowball sampling technique was employed to recruit FDW participants given its utility in reaching "traditionally underserved or vulnerable populations" (Sadler, Lee, Lim, & Fullerton, 2010, p. 369). Eligibility criteria for FDW participants included the following: (a) they had to be at least 18 years old; (b) they had to have at least a basic level of English proficiency; (c) they should have used Hong Kong health-care services at least once. The first author contacted religion-based organizations and nongovernmental organizations, which resulted in 12 FDWs expressing their interest in participating in the entire research; these FDWs formed the initial sample. The initially sampled participants were encouraged to refer other FDWs with the same characteristics. The recruitment of participants ended when data reached thematic saturation (Sada, Street, Singh, Shada, & Naik, 2011), resulting in a total of 30 FDW participants' involvement in this research.

FDW participants involved in this study included 11 Indonesians (36.67%) and 19 Filipinas (63.33%). Their reported ages ranged from 28 to 54 years, with an average age of 37.6 ( $SD = 7.5$ ). The average number of years they had worked in Hong Kong was 8.4 ( $SD = 6$ ). Almost all participants ( $N = 28$ ; 93.33%) had completed secondary education or higher. Medical complaints reported by FDW participants were common cold/flu ( $N = 15$ ; 50%), musculoskeletal pain ( $N = 10$ ; 33.33%), skin infections ( $N = 8$ ; 26.67%), gastrointestinal issues ( $N = 5$ ; 16.67%), and gynecological symptoms ( $N = 4$ ; 13.33%). Participants were asked how many times they had been to the doctor since they moved to Hong Kong: Fourteen (46.67%) answered three times, eight (26.67%) answered twice, four (13.33%) answered once, and four (13.33%) answered four times or more.

### ***Materials and Procedure***

This research mainly used semi-structured interviews to investigate FDW participants' perceived health-care experiences. Interview questions were designed to explore FDW participants' experiences of communicating with clinicians and perceived outcomes. Introductory questions inquired about participants' health-care experiences in general including the time of their most recent medical visit and their goals for medical consultations. In addition, participants were asked to rate their overall health status, "In general, how would you rate your overall health today?"; response options ranged from "very poor" to "very good", with "fair" as a neutral option. Several questions were designed to elicit FDWs' perceptions of clinicians' communicative behaviors, such as "In your experience, how much have clinicians asked you for your opinions about medical preferences or care?" and "Can you remember a moment regarding what health-care providers did to make sure you understood the information they provided?" To identify the health outcomes that FDWs perceived they had achieved, participants were asked questions such as those regarding their satisfaction with communication and compliance with medical instructions; examples of these interview questions included "What was the outcome of your medical consultation?"; "Were you able to follow any post-consultation medical instructions? Explain why"; and "In general, how satisfied have you been with your medical consultations?" Pilot testing of these interview questions was conducted with two FDWs to assess their understanding, but their responses were not incorporated into the final data analysis.

FDW participants were informed of the research purposes and procedures before participating in the research. They were assured that all information they provided would remain confidential. After the participating FDWs read and signed the consent form, they were asked to provide their demographic information and information about their health-care issues (e.g., times of medical visits in Hong Kong and medical complaints). Semi-structured interviews were scheduled at the convenience of the participants, conducted either by telephone or in person. Interviews were performed in “an unhurried and relaxed” (Hamilton, 2020, p. 198) atmosphere to ensure that participants were given sufficient time to provide their responses. Participants were given the opportunity to ask follow-up questions or ask for clarifications about the interview questions at any time. It took an average of 39 minutes for each interview to be completed. Each participant completing the interviews was offered a gift voucher worth HK\$20. All interviews were audio-recorded, transcribed verbatim, and uploaded to NVivo 12 for data analysis.

### ***Data Analysis***

Interview data were analyzed by employing thematic analysis because it serves as a flexible tool to “provide a rich and detailed, yet complex, account of data” (Braun & Clarke, 2006, p. 78). In accordance with Braun and Clarke’s (2006) description of the analytical process, the first author began by immersing herself in the data to increase familiarity with the participants’ accounts. A deductive approach was employed to understand certain aspects of responses concerning the research questions. Initial coding was performed across the whole data set that captured the data extracts central to the topic of interest as informed by Street and colleagues’ (2009) pathway model and previous literature (i.e., communicative process and health outcomes). Thus, we identified proximal outcomes and intermediate outcomes that FDWs perceived as pathways from communication to their ultimate health outcomes. Next, initial codes were refined and sorted into potential themes (including overarching themes and subthemes), and these themes were reviewed by referring to the coded extracts and the whole data set. Overarching themes and subthemes were defined and named, inspired by the constructs from the pathway model (Street et al., 2009). Specifically, proximal outcomes (e.g., patient satisfaction and trust in clinicians) and intermediate outcomes (e.g., acquisitions of self-care skills and adherence to treatment plans) were reported in the findings. Finally, data extracts representing illustrative points were selected as examples under each theme.

To promote data rigor, strategies including prolonged engagement and negative cases were adopted. First, the first author spent sufficient time with FDW groups to understand their health experiences, which potentially reduced “reactivity and respondent bias” (Robson & McCartan, 2016, p. 171). Second, the first author sought out disconfirming cases in FDWs’ accounts, which is a way of handling researcher bias (Antin, Constantine, & Hunt, 2015; Robson & McCartan, 2016). For example, there were two participants whose accounts differed from others in terms of the ultimate outcomes they achieved. They described that their health conditions did not improve despite their obedience to their clinicians’ medical instructions. Member checking was not performed because some participants did not respond to our subsequent contact attempts or changed their contact information without informing us, and there may be a problem with this method in that the participants may not be able to assess the data accurately because of the long time we spent transcribing and analyzing the data (Smith & McGannon, 2018).

## Results

### *Sample Characteristics*

Among the 30 participants, self-rated health status was reported as being "very good" by a third of the participants ( $N = 10$ ), as being "good" by slightly more than a half ( $N = 17$ ; 56.67%), and as being "fair" by three participants (10%). Concerning the ultimate outcomes for participants after the medical consultations, 18 participants (60%) reported being cured, and eight participants (26.67%) reported relief from symptoms; four participants (13.33%) did not report improvement in their health, so they either sought follow-up treatments ( $N = 2$ ; 6.67%) or self-medicated ( $N = 2$ ; 6.67%).

According to FDW participants' interview responses, their communication with clinicians impacted health conditions via proximal and intermediate outcomes. Following are excerpts that illustrate the proximal and intermediate outcomes as two overarching themes and their respective subthemes.

### *Themes Concerning Proximal Outcomes*

There were three subthemes arising from FDW participants' narratives regarding proximal outcomes. These were FDWs' satisfaction with clinicians' communicative behaviors, knowledge gained through communication, as well as trust in clinicians. FDW participants reported that these proximal outcomes were directly related to their communication with clinicians.

#### *Satisfaction With Clinicians' Communicative Behaviors*

As one of the proximal outcomes directly stemming from communication with clinicians, FDW participants' satisfaction was well represented through their perceptions of clinicians' communicative behaviors. Just more than half of FDW participants ( $N = 16$ ; 53.33%) indicated they were satisfied with the clinicians' communicative behaviors, while 13 (43.33%) indicated both satisfying and unsatisfactory aspects of clinicians' communicative behaviors. One participant (3.33%) did not mention the clinicians' communicative behaviors in her accounts.

Among those who expressed satisfaction, 12 participants (40%) underlined clinicians' positive affective behaviors, such as their willingness to listen to patients and their caring attitude (e.g., being friendly and supportive). As an example, one woman articulated that her clinicians' attentive listening contributed to her satisfaction, saying, "I'm very satisfied because they [doctors] focus on you and listen to you when they talk to you. You are only the patient, right? But they really listen for [to] the patient" (Participant#15, Filipina, 48 years old). Another woman who derived a great deal of satisfaction from her clinicians' communicative behaviors also stated that her clinicians exhibited favorable affective behaviors during medical consultations, such as amiability and composure, thereby helping her to not feel pressured and to be able to raise questions. She recounted,

Doctors there are very accommodating . . . I'm satisfied. Because they [doctors] are very friendly. Yeah, they're very friendly. And you know, you are comfortable to talk your problem to them, so you are not afraid that you ask a question. Very friendly, very easy to talk, very calm. (Participant#13, Filipina, 34 years old)

By contrast, a minority of FDW participants ( $N = 6$ ; 20%) noted that clinicians' task-oriented behaviors resulted in the former's satisfaction with care, including offering explanations and rendering clear medical instructions to patients. This can be demonstrated by one participant's statement, "Satisfying moment . . . because they make it easy to understand when they explain to me what I'm going to [should] do" (Participant#18, Filipina, 45 years old).

Among FDW participants who indicated their unsatisfying aspects of clinicians' communicative behaviors, some ( $N = 8$ ; 26.67%) noted that clinicians' undesirable affective behaviors, particularly their nonverbal cues, prompted their dissatisfaction with communication. In accordance with FDWs' accounts, clinicians' undesirable nonverbal cues were portrayed as a lack of eye contact, negative tone of voice (i.e., too high/low), and inappropriate facial expressions. As illustrated by one participant's account, "I feel I'm not [satisfied] when the, when the doctor said, talk like the unhappy face . . . Then, a high voice" (Participant#4, Indonesian, 37 years old). Likewise, another participant expressed her dissatisfaction with clinicians' engagement in computer-based activities while failing to maintain eye contact with patients during their conversations. Her clinician's behavior further discouraged her from engaging in their conversations. As she recalled,

Sometimes I'm not satisfied. Because when I go to see the doctor, I don't like it when I talk to doctor, they are reading [staring at] the computer. They don't look at me, pay attention to talking to me. Then I don't want to talk. This is from my side, my opinion. (Participant#28, Filipina, 43 years old)

### *Trust in Clinicians*

Trust in clinicians was a recurring subtheme in FDW participants' accounts. As narrated by these participants, their trust in clinicians primarily stemmed from one reason, which was their faith in their clinicians' technical competence.

Participants ( $N = 13$ ; 43.33%) emphasized that clinicians' technical skills, especially their grasp of medical knowledge, contributed to their increased trust in clinicians. For example, one Indonesian participant stated that she placed her trust in clinicians owing to her belief in the clinicians' medical knowledge, "The doctor is the one who I believe . . . Because she is the doctor, she know [knows] a lot about the problem, about healthy, health" (Participant#4, Indonesian, 37 years old). Likewise, another participant underlined that the diagnosis determined by her clinician was identical to her expected diagnosis, which she had researched on the Internet. The information symmetry, as a result, increased her trust in clinicians. As she recalled in her narratives,



Actually, I trust the doctor because, of course, he know my health. Because when he showed me the reason why I have that [gout], I already agreed that he knows about what guiding [leads to] my illness. I check online before, so I agreed already about the result that I have the uric acid. So I don't have any disagreement. (Participant#21, Filipina, 46 years old)

#### *Knowledge of Health-Care Issues*

A majority of FDW participants ( $N = 22$ ; 73.33%) reported knowledge deficits in their medical problems before medical consultations. Most of these participants ( $N = 17$ ; 56.67%) said their health-related knowledge increased after the consultations, which was mainly achieved through information exchange with their clinicians. For instance, a Filipina participant recalled that her clinician imparted health-related knowledge that she had not previously possessed, thus contributing to her increased understanding of health conditions. She reported,

Like, it was, it's the first time I learned that if you have cold, it can also affect your hearing like that . . . I feel good because the doctor eh, share some knowledge to me, that I learn from the doctor too. (Participant#5, Filipina, 40 years old)

Even though some patients reported they had acquired health-related information from different sources (e.g., employers and the Internet) before medical visits, they revealed that there still existed knowledge gaps in their health-care issues. However, clinicians' proper delivery of information during their communication filled their knowledge gaps to some extent. This could be demonstrated by the accounts of one participant, who was diagnosed with gout in her hand. She recalled,

I never doubt doctor's knowledge . . . Yeah, because you know, I talk to my boss before, she told me it's, maybe I do a lot of work. I'm not sure . . . My doctor check me and give me test. Then doctor said I have a higher uric acid, so if you have more urine acid, there [it] is possible to have gout also . . . That's why my hand is getting numb. This is something I don't know before. I'm happy to learn that. (Participant#21, Filipina, 46 years old)

Participants described how they employed various communication tactics to enhance their understanding of medical concerns. One participant believed that her question-asking behavior displayed in front of clinicians resulted in her knowledge increase, which would inform her next steps of treatment actions. She said, "I ask question to doctors so I know more about my problem . . . because I want to know more the detail, then I will know what I have to do" (Participant#4, Indonesian, 37 years old).

However, not all the participants stated they gained knowledge from their communication with clinicians. A few participants ( $N = 5$ ; 16.67%) acknowledged that, due to time constraints, they failed to gain the information they needed from clinicians. This was demonstrated by one participant's account:

I want to know more, more and more, and I want to know clearly, yes. That's mean [That means], [I] need time for the doctor to explain to me. Otherwise [However], there's line up patient outside, so doctor don't have much time to, for me. (Participant#2, Indonesian, 48 years old)

Another participant recalled a similar experience: "The doctor is always in a hurry, so, you know, they cannot tell you properly what's happening to you" (Participant#24, Filipina, 30 years old). Her clinicians' lack of explanation, as a consequence, provoked her uncertainty and fear over unprecedented health outcomes following treatment, "I'm scared, I don't know what [will] happen to me" (Participant#24, Filipina, 30 years old).

FDWs' accounts indicated three proximal outcomes directly deriving from their communication with clinicians: Satisfaction with clinicians' communicative behavior, trust in clinicians, and acquirement of medical knowledge. In FDWs' explanations, clinicians' communicative characteristics, competencies in expertise, and their information exchange with patients were the primary factors behind these proximal effects.

### ***Themes Concerning Intermediate Outcomes***

Two subthemes, FDWs' adherence to clinicians' medical instructions and acquisition of self-care, emerged in FDWs' accounts as intermediate outcomes that linked proximal outcomes to ultimate outcomes. It follows that FDWs reported such intermediate outcomes in relation to the extent to which they felt cured or the extent to which they experienced relief from their symptoms.

#### ***Adherence to Clinicians' Medical Instructions***

One issue labeled as an intermediate outcome was adherence to clinicians' medical instructions, which was mentioned by FDWs in their narratives. FDW participants ( $N = 11$ ; 36.67%) said their adherence to medical instructions was partially attributable to their satisfaction with clinicians' communicative behaviors. As evidenced by a Filipina participant's account, her clinicians' affective behaviors displayed during medical consultations contributed to her commitment to her assigned treatment regimen, "Yes, I follow [doctors' instructions] . . . Because the doctor is very polite. She [the doctor] respect me. I'm very satisfied" (Participant#26, Indonesian, 32 years old). Similarly, another FDW participant cited her satisfaction with clinicians' instrumental behaviors, represented by their detailed explanations of the treatment procedure, as a reason for following her clinicians' medical instructions:

Because she [the doctor] really explain it to me. She told me what was good for my nail [nail's] fast recovery, what is the full process of curing this. I'm very, very satisfied with that. For example, what is the best tool for me, what is the best medication for my nail problem, something like that. That's why I want to follow. (Participant#19, Filipina, 31 years old)

Meanwhile, 12 FDWs (40%) reported that their decision to follow or not follow clinicians' treatment instructions could be ascribed to their trust in clinicians, particularly in clinicians' competence in technical skills and grasp of medical knowledge. This was demonstrated by one participant's explanation:

I want to follow their instruction because I trust them. I believe they can help me release [alleviate] my pain, help me solve my tooth problem. They are the one who really know, because they're professional about these kinds of things. There's no way if I don't follow their advice. So, I really need to follow. (Participant#18, Filipina, 45 years old)

A small number of participants ( $N = 5$ ; 16.67%) admitted that they failed to follow clinicians' medical instructions, mainly due to their dissatisfaction with clinicians' communicative behaviors. Participants stated that their dissatisfaction could be attributed to an insufficient exchange of information; in other words, their clinicians spent little time talking to them and failed to explain their medical problems in detail. One participant diagnosed with an abscess in the right axilla recalled,

I asked them why I have this problem and then they just, they just gave me some medical terms and explained to me very short, which I didn't fully understand . . . Then they just gave me the tablets and then the cream. I'm not sure if they gave me right medicine because I don't have time to ask. So, I only use it [the medicine] for two days. After that, I never use again. (Participant#14, Filipina, 38 years old)

Most FDWs ( $N = 23$ ; 76.67%) reported that their adherence to medical instructions in turn had direct effects on their clinical outcomes and whether they felt cured or relieved from their symptoms. This could be demonstrated by the statement of one participant who reported on her commitment to adhering to medical instructions: "I follow their instruction so I can stop my cough, so I can get better soon" (Participant#29, Indonesian, 36 years old). Two disconfirming cases were identified: Two participants reported that though they did comply with clinicians' medical guidance, they were unable to achieve improvement in health status. Instead, they had to make follow-up visits due to the ineffectiveness of the medication prescribed by their clinicians. Having reported symptoms of a sore throat, one participant recalled, "Yeah, I finished the medicine. And then, after a week, it [the medicine] never work. I go back to doctor again, and then ask them again" (Participant#16, Filipina, 54 years old).

#### *Acquisition of Self-Care Skills*

Several participants ( $N = 7$ ; 23.33%) reported that they adopted various self-care strategies after their medical consultations. The strategies covered included physical activity, diet, and sleeping patterns as well as the use of various vitamin supplements.

As described by these FDWs, clinicians offered self-care advice during their interactions, thereby increasing their knowledge of health promotion. Accordingly, FDWs believed that the knowledge they gained from medical consultations enhanced their awareness of healthy living and motivated them to adopt healthy habits. The following is a quote from a participant diagnosed with migraine:

He [doctor] suggested some good habits that might help me relax. He suggests me to sleep early. He suggests me also to eat healthy foods and avoid eating chocolates or drink alcohol like that, because they may trigger my migraine. This is the first time I know chocolate can cause this [migraine] . . . yeah, I don't know this before . . . [After] talking to doctor, I'm so conscious about health. I exercise every day. I follow doctor's advice about vegetables, so I'm eating more vegetables. I sleep early. I also drink ginger tea because doctor say it's good for me, and lemon water. Oh, no chocolate, of course. (Participant#27, Filipina, 33 years old)

At the same time, FDWs acknowledged that their trust in clinicians predisposed them to perform self-care practices as well. FDWs identified that clinicians validated their concerns and encouraged them to adopt healthy behaviors, increasing their trust in clinicians. Consequently, they would opt for altering unhealthy behaviors and practicing self-care. For example, one participant reported that she acted on her clinicians' self-care advice due to her trust in clinicians:

Doctor tell me, "I can understand. Don't worry, you will be ok. You have to take care of yourself well so you can work better and send money back home." So, we talk a little bit personal life. I feel secure because the doctor can give me more suggestions about how to stay healthy and take care of myself, and I like to listen more what the doctor say to me. I trust her very much . . . After that [medical consultation], I know what happened with me and I know how to take care of myself. I follow their [doctors'] suggestions. Like, I can exercise and eat healthy food. (Participant#29, Indonesian, 36 years old)

Self-care practices were observed to have been beneficial for FDW participants, as they reported feeling cured or relieved from symptoms by keeping up with their routines and self-care practices. This allowed FDWs to feel empowered to prevent future relapses of their illnesses. One participant stated,

You know, I listen to doctor. They tell me what I [should] do, what I shouldn't [do]. So I really have to follow their advice, I need to care about myself . . . I have to refrain from eating soybeans, and I need to relax. Even sugar, I have to be careful with that . . . No, I never sense gout anymore, I feel good. (Participant#21, Filipina, 46 years old)

FDWs' narratives described compliance with clinicians' treatment plans and self-care skills as their perceived intermediate outcomes. Treatment compliance was achieved by FDWs' satisfaction with clinicians' communication and trust in clinicians (proximal outcomes), and knowledge acquired and trust in clinicians (proximal outcomes) contributed to FDWs' self-care skills. These intermediate outcomes were believed to be directly responsible for curing or relieving symptoms (ultimate outcomes) among most FDW participants.

## Discussion

Notwithstanding the significance of PCC and health outcomes, there remains a paucity of empirical research into how PCC can influence health outcomes, particularly from the perspective of disadvantaged racial and ethnic minorities. Owing to their position as a disadvantaged group whose rights are legally and

socially restricted, FDWs are at risk of poor health status. This study examined the role communication with clinicians may play in FDWs' perceived health outcomes, which could facilitate effective interventions to support FDWs' well-being. Combining key constructs from Street and colleagues' (2009) model of pathways from communication to outcome, this study analyzed FDWs' reported beliefs and perceptions after they received health-care services in Hong Kong. By doing so, we attempted to achieve the major objective of this study, which was to identify the mechanisms through which PCC influences patients' optimal outcomes. Specifically, we asked two research questions to better understand FDWs' perceptions.

***RQ1: What Are the Proximal Outcomes That Result Directly From PCC?***

Three proximal outcome-related themes were identified in FDW participants' accounts: Satisfaction with clinicians' communicative behaviors, trust in clinicians, and knowledge gained about health-related issues. First, FDW participants expressed that their satisfaction was chiefly reflected through clinicians' communicative behaviors, implying the direct effect of communication on FDWs' satisfaction with care. Interestingly, FDW participants laid more emphasis on clinicians' affective behaviors than task-oriented behaviors, which may be partly because clinicians display more affective behaviors compared with instrumental behaviors in their communication with migrant patients (Schouten, Meeuwesen, Tromp, & Harmsen, 2007).

Second, FDWs reported that their clinicians' technical competence displayed during their communication increased their trust in clinicians. This finding corroborates that of Greene and Ramos (2021), who conducted a mixed-method study with a diverse sample (including Black and Latino patients) and concluded that clinicians' demonstration of competence was closely associated with patients' strong trust. Third, FDWs pointed out that their knowledge pertaining to health-care issues increased after communication with their clinicians. It should be noted that a few participants did not report their knowledge gain after consultations because of the limited consultation length; another possible explanation for their failure of knowledge gain could be that some FDWs reported limited English or Cantonese proficiency, indicating their minimal information exchange with clinicians (Sarkar, Asti, Nacion, & Chisolm, 2016; Vandan, Wong, & Fong, 2019).

***RQ2: What Are the Intermediate Outcomes That Impact FDWs' Perceived Ultimate Outcomes?***

Two salient intermediate outcome-related themes emerged from participants' accounts: Adherence to clinicians' medical instructions and acquisition of self-care skills. As a direct consequence of their satisfaction with clinicians' communicative behaviors and their trust in clinicians, most FDW participants believed their compliance with clinicians' medical instructions would subsequently contribute to their improved health. These results are consistent with the findings in many previous studies (e.g., Barbosa, Balp, Kulich, Germain, & Rofail, 2012; Naghavi, Mehroolhassani, Nakhaee, & Yazdi-Feyzabadi, 2019; Ng & Luk, 2019; Street, 2013). Two negative cases pertained to two participants who did not report health improvement even though they followed medical instructions, which lends empirical support to Becker's (1985) notion that patients' high compliance level alone is not always related to improved health. It is possible that these negative cases present opportunities for further research (Hamilton, 2020). For example, future studies can uncover plausible reasons for attenuating the effect of PCC on health outcomes. FDW participants also noted that trust in clinicians and knowledge gained prompted them to perform self-care; their accounts provided empirical evidence to little published data on how patients' trust in clinicians directly

affects their self-care practices (Bonds et al., 2004). FDWs' acquisition of self-care skills, in turn, contributes to their improved health.

### ***Theoretical and Practical Implications***

This qualitative study supports Street and colleagues' (2009) model of pathways from communication to health outcomes, a model that rarely receives empirical support (Jiang, 2017). These findings lend credence to Street and colleagues' (2009) view that PCC often affects health outcomes through an indirect route, mediated by proximal and intermediate outcomes. Traditionally, the pathway model (Street et al., 2009) is used within quantitative, correlational research. This study expanded the use of the pathway model (Street et al., 2009) by incorporating it into the analysis of FDW patients' narratives (i.e., Hong Kong FDW patients' perceptions and beliefs in this study), demonstrating the model's potential for examining minority patients' health-care experiences in Asian clinical settings. The analysis of FDW patients' narratives in this study serves as an exemplar, opening up new avenues to apply the pathway model (Street et al., 2009) to explore new pathways connecting communication to outcomes based on patients' perceptions.

Practically, the insights from this study can assist in designing interventions that contribute to FDW patients' improved outcomes. First, FDW patients accentuated the direct influences of communication on their trust in clinicians, satisfaction with care, and knowledge gains. As a few participants expressed their dissatisfaction with insufficient information exchange, clinicians are supposed to impart health-related knowledge tailored to FDW patients' informational needs and leave room for patients to speak up. Meanwhile, given some FDW participants' emphasis on clinicians' affective behaviors, clinicians are advised to make efforts to deliver patient-centered responses (such as attentive listening and avoidance of disengaged nonverbal cues) during their interactions. Second, FDW participants mentioned that their adoption of self-care practices was primarily attributable to their trust in clinicians and clinicians' self-care advice. Apart from clinicians' efforts, FDWs are encouraged to improve their self-efficacy in promoting health and build confidence in preventing potential disease. Third, a small number of FDW participants pointed out that they failed to achieve optimal outcomes despite their compliance with medical instructions, which required them to make follow-up visits. To ensure the continuity of care and that FDWs can seek immediate medical attention after failing to achieve good health, health-care organizations need to consider implementing e-consultation platforms that facilitate patients' effective communication with clinicians.

### ***Limitations and Directions for Future Studies***

A number of limitations exist that are worthy of attention in future studies. The first limitation is that a snowball sampling method was deployed to recruit FDW participants due to which these findings may not be generalizable beyond this sample. Future studies should consider increasing the number of FDW participants and involving more diverse FDW groups (e.g., FDWs with work-related musculoskeletal problems and gastrointestinal health issues). Second, the health outcomes presented in this research relied on participants' self-reported data. FDWs' perceptions of achieved outcomes do not necessarily reflect the reality, and there is a possibility that participants provided socially desirable responses during the research, which may interfere with the accuracy of data interpretation. It is recommended that future studies refer to more objective assessments that reflect FDW patients' health status. For example, FDW patients' medical

records (initial visits vs. follow-up visits) could be reviewed with permission to gain a more objective assessment of their health status. Third, this research adopted a qualitative approach to examine how communication is concerned with outcome-related constructs (including proximal outcomes, intermediate outcomes, and ultimate outcomes), without the use of statistical tests to further test the relationships. A mixed-method approach should be adopted in subsequent studies to not only validate the qualitative results and substantiate the linking pathways between FDW PCC and outcomes but also ensure there are qualitative data to embellish the statistical findings. Finally, only a few outcome-related constructs were examined in this study. Other proximal and intermediate outcomes, such as patients' motivation to adhere and social support, or the combination of communication and contextual factors may suggest new pathways linking communication to health outcomes.

However, this study represents an important step in better understanding the dynamics of FDW medical consultations and sheds light on some ways in which these consultations could be improved. The next step is to expand the research as suggested above to further assist FDWs and advise health-care professionals in meeting the health-care needs of this disadvantaged population.

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