EDUCATION FOR HEALTH

ORIGINAL RESEARCH PAPER

General Population and Medical Student Perceptions of Good and Bad Doctors in Mozambique

A Pfeiffer[1], BH Noden[2], ZA Walker[1], R Aarts[3], J Ferro[1]

[1]*Faculdade de Ciências de Saúde, Universidade Católica de Moçambique, Beira, Moçambique*

[2]*Department of Biomedical Science, School of Health and Applied Science, Polytechnic of Namibia, Namibia*

[3]*Symfora Group, Amersfoort, The Netherlands*

Published: *April 2011*

Pfeiffer A, Noden BH, Walker ZA, Aarts R, Ferro J

General Population and Medical Student Perceptions of Good and Bad Doctors in Mozambique

***Education for Health*, Volume 24, Issue 1, 2011**

Available from: http://www.educationforhealth.net/

ABSTRACT

Context: A key element of the doctor-patient relationship is to understand the patient's and doctor's perceptions of quality care.

Objectives: To assess the perceptions of good and bad doctors among first-year medical students and local community members in a semi-urban, African setting.

Methods: Using open-ended and closed dichotomous questions, 115 first-year medical students in Beira, Mozambique were surveyed regarding their perceptions of a 'good' and 'bad' doctor. Students then surveyed 611 community members in a predominately poor, semi-urban neighbourhood.

Results: Answers to open-ended questions provided by both groups produced the same four most important positive characteristics, with good diagnostic and therapeutic skills and dedication ranked highest. Closed-ended questions revealed that local community members felt that being concerned/considerate and diagnosing well were equally important (19.5% and 17.5%, respectively) compared to students (17.5% and 41.2%, respectively). The most important negative characteristics to the open-ended question for both groups were discrimination and contemptuous behaviour: 29.3% for community members and 27.4% for medical

students. The biggest difference between groups was poor attending skills: 17.3% by community members and 3.9% by medical students.

Conclusion: This study highlights differences and similarities between the perceptions of medical students and community members concerning a 'good' and a 'bad' doctor. Our data suggest that perceptions are guided by the experiences and values of those interviewed. Results indicate that medical education in developing countries should focus on patient-centered care, including communication skills and attitudes, besides training knowledgeable doctors.

Keywords: Africa, bad doctor, communication skills, community perceptions, good doctor, medical education, medical student perceptions, Mozambique, patient attitudes

Introduction

Everyone wants to be examined by a 'good' doctor, but what does 'good' mean? While some stress the importance of personal qualities over technical skills[1-5], others emphasize the need for competency and technical skills[6-9]. Still, others focus on the need to identify with the patient[10-14]. With these differing views, one thing continues to be clear: the development of a mutual understanding between doctors and their patients, particularly focusing on values and experience, increases both compliance and trust[15,16].

Through the years, various studies have approached the topic of a 'good' doctor by surveying the responses of patients (Europe[3], Israel[7], Ireland[12], Switzerland[13], United States[9,16]), community members (Tanzania[1], Zaire[2], Singapore[6], Ireland[12], Guinea[17]), medical students (Brazil[5], United Kingdom[14]) and doctors (Singapore[6], Germany[8], Spain[18]). Clearly, the majority of studies have occurred in Western countries as the medical profession has adapted to an unprecedented global migration which is significantly altering doctor-patient interactions[15,19] and has become more attuned to the diverse needs of minority ethnic communities in their own countries[16,20,21]. These studies suggest that personal experiences, family attitudes, cultural understandings of health and illness and group beliefs concerning patients' preferences shape interactions with patients from different cultural backgrounds[16,20,21]. The issue now not only focuses on what a 'good' doctor is in a particular setting, but also requires better understanding of how to provide 'good' care to one's patients, no matter their ethnicity[15,16]. Few studies, however, have investigated the perceptions of a 'good' doctor from the perspective of diverse populations in developing countries.

While not directly addressing the perceptions of 'good' doctors, studies from developing countries provide general ideas of what community members value in a 'good' doctor. First, like Western patients[3,13], the desire of community members is to interact with a medical professional who is concerned for their well-being (i.e. patient-centered care)[1,2,17,22]. Secondly, past studies have begun to address the cultural values of community members as well as their experiences with the medical systems in developing countries. These experiences directly impact how community members respond, thereby producing an interesting association between the perceptions/desires of the community and the reality in the medical system[1,22,23]. These studies, however, only provide glimpses into the values of patients in developing countries, and there is clearly a need for more work to address this issue[22].

This subject directly impacts the setting in which the authors work in Central Mozambique. The Catholic University of Mozambique (Universidade Católica de Moçambique, UCM) is located in the city of Beira and is surrounded by a low-income community. The Faculty of Health Sciences consists of African and Western trained physicians and research doctors of diverse origins that are focused on training future Mozambican doctors. In this setting, the differences between the perceptions and

experiences of the students and patients may be different[23,24] than in Western settings and will include their cultural understandings of illness and health[25-29]. Without awareness, these differences can disconnect doctors and those they train - both Mozambican and international - from the perceived needs of the local community. Additionally, most incoming medical students to our faculty come from a higher socio-economic class than the inhabitants in the surrounding community. These students may have different perceptions of the medical profession which may differ significantly from those in the community in which they will be trained. Therefore, to facilitate the cultural learning in our medical school, our objective was to identify the characteristics that the population surrounding the medical school look for in a 'good' and 'bad' doctor and compare them with those identified by the incoming group of medical students.

Methods

Study setting

This study was part of an introduction for first-year medical students to the people and environment of the local community surrounding the medical school, and was approved by the Institutional Research Advisory Committee. Family and Community Health is an important part of the UCM curriculum and after the first year, each student is linked to five families in the local community (population: ~50,000) which surrounds the medical school. Because of this interface, we felt it was critical to assess the responses of both first-year medical students and community members concerning their views on desirable and undesirable characteristics of doctors.

The 'bairro' surrounding the medical school consists of residents who are either unemployed or marginally employed (informal sector) and worry more about shelter and food than their health. They lack a basic sewage system and garbage facilities with only a few residents having access to running water or electricity. As with most of the 'bairros' in Beira, when it rains, the community fills with water, which has led to frequent outbreaks of diarrhoeal disease, measles, cholera and malaria. HIV/AIDS is also a major concern.

Study participants

Three months after beginning their first year at the UCM Faculty of Health Sciences in Beira, Mozambique, students were introduced to the Family and Community Health program. Over a period of one week, they learned the details of the program and trained in interviewing skills, including role-playing, and how to interact respectfully with the local community. As part of the introduction on the first day, the authors surveyed the students for their opinions of characteristics of 'good' and 'bad' doctors by asking them to complete a semi-structured questionnaire in Portuguese. While participation was optional and they were not graded for their answers, all 115 students were eager to participate.

Prior to conducting the community portion of the study, all community leaders were informed and gave their approval. On the two days where the students were going to administer the survey, community volunteers, already involved in the Family and Community Health program and chosen by community leaders, assembled at the University to accompany the students and faculty members. The community was divided into six areas with one-half of the students visiting three areas on one day and one-half visiting the remaining areas the second day. Entering into the community, students divided into groups of 20 with a faculty advisor, 4th year students who knew the community well, and community volunteers who ensured the safety of the students. Each group went to a particular area of the local community and the groups dispersed into their area in pairs. By dividing the community into

six non-overlapping areas, we tried to ensure that community members only responded to one survey. Using a convenience sampling technique, each student interviewed five to six persons within a one hour period wherever they encountered them (sitting in front of their homes, working in a market stall, walking in the street, etc). Before giving their opinions, community members provided informed oral consent.

Responses were written anonymously and complete confidentiality was guaranteed. The interviewers were instructed to speak to people from different age groups (minimum age 15 years[12]), noting the age, gender and educational level of the interviewee. Community members were very amenable to the students' requests for interviews and there were no refusals or adverse effects needing intervention. All surveys were returned to the school after the interview period was completed.

Questionnaire

This consisted of two parts. The first section contained two dichotomous open-ended questions: 'What specific characteristics would you like to find in a doctor? Mention the two most important ones'; 'What specific characteristics would you not like to find in a doctor? Mention the two most important ones.' The question was dichotomized to more fully understand local concepts of good and bad doctors.

The second portion of the questionnaire consisted of two lists of 10 characteristics from which interviewees chose the best characteristics of a 'good' doctor and the worst characteristics of a 'bad' doctor (Table 1). The characteristics were derived from two pilot studies with two diverse populations in Beira (clinic outpatients and economics students) who were not involved in the final study. During the interviews, the characteristics in the lists were shown and read to interviewees. This part of the questionnaire was used to confirm patterns of thinking encountered in the open-ended question responses. The semi-structured questionnaire was produced in Portuguese then translated into the two most frequently used local dialects (Sena and Ndau) if the interviewee was not comfortable with Portuguese. Copies of the surveys are available, in English and Portuguese, from the corresponding author upon request.

Table 1: Lists of positive and negative characteristics of physicians presented to medical students and community residents

Positive characteristics	Negative characteristics
Against corruption	Motivated by money
Patient	Impatient
Calm, sympathetic	Not sympathetic
Diagnoses well	Does not investigate well
Respects the patient	Discriminates against patients
Concerned and considerate	Does not care about the patient
Explains well	Does not know how to explain well
Good personal appearance	Disarranged personal appearance
Confidential	Not confidential
Listens to social problems of the patient	Does not listen to the patient's problems

Analysis

Following Luthy et al[13]., two authors, familiar with local culture and Mozambican Portuguese, subjected the open-ended question responses to content analysis, and a list of 10 key themes/categories was created. The authors then independently classified the

open-ended question responses with subsequent 'cross-checking' by the other. Differences of opinion were regularly discussed and disagreements were resolved by consensus. For example: for a response to a 'bad doctor', person 208 said: 'doctors need to speak many languages. Principally, the ones who come to Africa need to know how to speak traditional [African] languages'. One author felt that this focused on good communication skills but the other felt there were aspects of motivation (dedication) and/or respect behind the response. After discussion with Mozambican colleagues, it was decided that it was 'too general to be classified'.

Chi-square statistics were used to compute comparisons between several variables. Values with p-values <0.05 were considered significant. Descriptive analysis was accomplished using EPI Info version 3.2.

Results

For the 115 first-year medical students surveyed, 67.5% were female, with ages ranging from 17 to 40. For the 611 persons interviewed in the nearby community, 46.3% were female and 53.7% were male, ranging in age from 15 to 85 years old. Related to education, 13.4% of those interviewed had never been to school, 54.2% had been to primary school (grade 1-7), 31.1% had been to secondary school (grade 8-12) and the remaining 1.3% were in university.

Comparing the answers to the open-ended questions from the community members with first-year medical students in regard to characteristics of a 'good' doctor (Table 2), the four most important positive characteristics (all over 10%) were the same. While the community felt that good diagnostic and therapeutic skills was the most important characteristic (18.9%) followed by dedication (14.9%), the sequence was the opposite for medical students, with 30.0% of students responding dedication on the part of the doctor. Both groups ranked confidentiality and good personal appearance as the lowest traits of a good doctor. Differences occurred regarding communication skills and attending skills, as community members mentioned both more often than students.

When selecting from the fixed list of 10 positive characteristics (Table 1), results differed in magnitude but not in general order of importance between the two groups. Community residents felt that being concerned and considerate and diagnosing well were the most important characteristics (19.3% and 17.5%) while students felt that diagnosing well was by far the most important characteristic (41.2%), followed by being concerned and considerate (17.5%).
With respect to open-ended responses to characteristics of a 'bad' doctor, both groups ranked discrimination and contemptuous behaviour most frequently (Table 3) – 27.4% and 16.5%, respectively, for students, and 29.3% and 17.3% for community residents. The next highest ranked were being corrupt and dishonest. The biggest difference between groups was poor attending skills, ranked second for the community but eighth by students.

Similar to the students, when choosing from the fixed list of 10 negative characteristics (Table 1), community members were most concerned about uncaring doctors (23%), with discrimination as a close second (19.3%). The students clearly felt that discrimination was most negative (35.1%), with lack of care ranked second (13%). Community members (9.6%), more so than students (2.6%), expressed concern about impatient doctors.

There were no statistically significant responses to good and bad doctor characteristics related to gender on the part of community residents. However, for students regarding good doctor characteristics, more males (47.3%) than females (22.1%) ($p < 0.010$) indicated dedication and concern for the patient as a characteristic of a good doctor. On the other hand, when selecting from the fixed list of 10 positive characteristics (Table 1), more females (51.3%) than males (21.6%) ($p < 0.003$) responded 'diagnoses well' as a positive characteristic of a doctor.

Table 2: Responses to open-ended question from first-year medical students and community residents about characteristics of a 'good' doctor

Characteristic	First-year medical students percent response (%)	Community residents percent response (%)	Community resident response examples
Dedicated (including concerned, considerate and motivated)	30	14.9	Person 517: "…gives medication and asks the patient to come back in order to find out if the medication worked…" Person 535: "… gives attention to the patient…" Person 122: "… who touches the patient and takes him there…"
Good diagnostic / therapeutic skills	18.7	18.9	Person 8:"… observes well and knows what the patient has…" Person 11: " … who gives the correct prescription…" Person 40: "… when after an operation the patient does not die…"
Patient	14.8	12.8	Person 298: "…patient, trying to understand what the patient wants to say…" Person 31: "... patiently questions the patient..."
Positive personal characteristics (including calm, sympathetic, caring and supporting)	14.8	12.8	Person 191: "… does not shout at the patient" Person 313: " being human, he who understands the patient…" Person 287: "… shows a smile during the consultation… "
Respectful and non-discriminating	5.8	9.3	Person 324: "…speaks to everyone in the same way…" Person 257: "…the doctor can't be put off by the patient…"
Honest and against corruption	5.6	1.7	Person 192: "… attends well with or without money…."
Good attending skills (including time keeping and not being dismissive)	3.9	10.2	Person 135: "…gives priority to the more severely ill patient" Person 187: "… attends the patient as soon as he arrives…"
Skilled in communication (referring to listening and explaining)	0.9	8.9	Person 162: "…who listens to what the patient says…" Person 230: "… knows how to explain what the patient needs to hear…"
Confidential	0.4	0.7	Person 27: "… if I was to have a very dangerous illness, he would not tell anyone else…"
Good personal appearance	0	0.3	Person 327: "… must have very white clothes…"
Too general to be classified	5.2	9.5	Person 580 "…a doctor who does not kill the patient…"

Discussion

To our knowledge, this is the first qualitative study from Africa to investigate the positive and negative perceptions of the medical profession outside the medical school setting. This study not only detailed the expectations of the local community and first-year medical students, but also provided students with the opportunity to personally interact with members of the same community that they will serve in during and after their medical training. The students themselves heard from community members how they desired to be treated, which contributed to the development of the students' own values and attitudes. While patient-centered care is a major focus of Western medical training, it is rarely emphasized in medical training in developing countries[22]. At UCM, the faculty aims to provide a quality medical education as well as prepare students to personally interact with community members through a family and community health component in the curriculum. The UCM curriculum addresses patient-centered care in its communication skills program, as well as in the family and community health program. While this training is important, it is not

always taken seriously as most students do not see the 'practical' value[30]. It may be possible to increase student interest in the patient-centered programs by giving more weight to the assessment of these skills[31]. This study was an important first step to encourage a practical dialogue between incoming medical students with their future patients in the surrounding community.

Table 3: Responses to open-ended questions from first-year medical students and community residents about characteristics of a 'bad' doctor

Characteristic	First-year medical students percent Responses (%)	Community residents percent responses (%)	Community resident response examples
Discriminating and contemptuous	27.4	29.3	Person 480: "…a doctor who sees me as any old bug in the bush" Person 354: "…doctor who chooses to attend coloured girls first and then me, who is a black woman" Person 383: "who attends his family members first…" Various persons (eg. 467, 342): "… who hits the patient…"
Corrupt and dishonest	16.5	12.1	Person 267: "…doctors who accept money to kill their patients" Person 434: "... uses his profession to other ends…"
Impatient	14.3	7.4	Person 32: "…irritable doctor…"
Poor diagnostic and technical skills	12.2	7.4	Person 52: "…does not send you to take a photo (X-ray) to see your illness" Person 242: "…not careful: does not analyse well and gives wrong medication…"
Not dedicated	9.1	12.0	Person 165: "…a doctor who writes the prescription before the patient has finished speaking" Person 196: "… abandons the patient when he most needs the doctor…"
Poor personal appearance	4.3	2.6	Person 7: "…a doctor who is drunk…" Person 20: "… badly dressed (dirty white coat and untidy clothes)..."
Negative personal characteristics	3.3	2.2	Person 207: "… doctors who don't touch the patient…"
Poor attending skills	0.9	17.3	Person 439: "a doctor who does not attend patients because he is having lunch…"
Not confidential	0.9	1.0	Person 12: "…. Does not know how to keep a secret…"
Poor communication skills	0.1	1.7	Person 6: "… a doctor who does not know how to speak nicely with the patient…"
Too general to be classified	10	7.0	Person 475:"… does not attend well a person…"

According to our findings, the characteristics of a bad doctor are not opposite to those of a good doctor, which reinforces the results of a Swiss patient study[13]. The responses of both community members and students highlighted different perceptions based on the experiences and values of each group, instead of a pre-defined list of categories. For a 'good' doctor, both pointed to essentially the same four characteristics for the open-ended question, with good diagnostics/therapeutic skills and dedication considered most important. The 'bad' doctor characteristics for both groups were also essentially the same with discriminating and contemptuous mentioned most often, followed closely by dishonesty and corruption. In general, while most students felt that technical aspects and competencies (diagnostic/therapeutic skills and dedication) were most important, community members considered interpersonal skills and patient-centered care (being concerned and considerate, having good attending and communication skills) as important as diagnostic/technical skills, consistent with the past literature[1,2,13,30].

Both cultural values and personal experience may account for these responses. With respect to the characteristics of 'good' doctors, the community members and students may have responded with their experience with traditional healers[1,22] which form a parallel medical community in Mozambique[32,33]. A person who goes to a traditional healer is usually 'received well' which means to be welcomed without discrimination, made to feel comfortable and provided with the attention that most Western-based patients expect from their doctors (i.e. patient-centered care[13])[1,22]. Their treatment also includes a diagnosis which is provided after a lot of testing[1,2,17,22]. In regard to the negatives, both the students and community members have likely had negative experiences in the national health care system. As others have reported[23,24,34], this regularly involves both discrimination of choosing patients who can afford more personalized attention, and corrupt practices, like bribery and paying for basic items in the hospital. For this reason, community members most likely want good doctors, like their traditional healers, who have both interpersonal as well as diagnostic skills. Similarly, their bad doctor characteristics may reflect their experience with the current public medical system[22].

The responses of the medical students were similar to first-year students in South Africa[30] but differed from studies in the United Kingdom[14] and Brazil[5], where a higher value was given to interpersonal skills and patient-centered care. This may have to do with different experiences and exposure to the national health system. For example, students have different experiences with doctors' behaviour with patients from different educational and socio-economic groups[35]. Cultural aspects may also play a strong role in medical student responses with 'nurturing' cultures which score higher on the 'caring' scale[5,22]. From the perspective of our study, it was valuable to learn of the expectations of the first-year students as they began their training so they can become aware of attitudes and responses that might be in need of modification[30].

We recognize various strengths and weaknesses in this study. In addition to a large study sample, a strength was our open-ended format of questioning, also used by Walter et al[12]. and Luthy et al[13].. The open-ended enquiry format provided ample access to diverse ways of thinking between our study groups. We were able to gather information on expectations which were based on experiences and cultural priorities, not on a pre-set group of categories. Additionally, we were able to measure a wide cross-section of the population. While not random, the data provided unique comparisons.

In terms of study weakness, interviewer bias was a possibility. Although instructed to help community members develop answers to the open-ended questions, it is not possible to know how interviewees were assisted during their interviews. That said, if an interview bias was present, we did not observe it given the large diversity of responses. Another possible limitation involved translation bias in two different areas. When presenting the survey, the students recorded what community members answered as accurately as possible, even if it involved translating from the local languages into Portuguese. It is possible that with the translation came a slight change in meaning. To counter this effect, students interviewed community members in pairs and we ensured that one of them was fluent in the local languages. Additionally, the authors relied on Mozambican faculty/staff members to decode the responses provided for the open-ended questions when organizing the final thematic categories. While Portuguese is the national language of Mozambique and the authors have ample Mozambican experience, the Portuguese used in the local community is not always correct in the truest sense, and meanings can differ.

Overall, this study highlighted interesting similarities and differences in perceptions regarding a good doctor between incoming medical students and community members from a surrounding poor, semi-urban neighbourhood. Results provided a description of cultural values and experiences from two different populations in Mozambican society that encouraged a greater focus on patient-centered training at our institution. The importance of these results goes beyond developing countries, however, as the need to train doctors to meaningfully interact with patients of diverse ethnicities and socio-economic backgrounds is a globally recognized need[16,36]. Many creative ideas exist to provide cross-cultural experiences by adding components to medical school curricula such as

appreciation for patient experience, acquisition of explanatory models of illness and disease, comprehension of cultural values and behaviours, and the creation of educational resources to better understand the cultural, social and economic dimensions of patients[16,20,27,35-37]. This need becomes even more critical when Western-trained doctors and researchers work in cross-cultural partnerships with medical schools in developing countries[16,38-41].

Future longitudinal studies should evaluate the behaviour and perceptions of doctors in and surrounding medical institutions in developing countries with a distinct patient-centered focus in their curricula. As these schools continue to train patient-oriented doctors, a follow-up study in the local community will indicate how perceptions have changed over time due to the differences experienced by community members. There is no doubt that this would improve the level of trust, as well as ensure more effective usage of the medical facilities[1,15,17,20]. It would also be advantageous to complete a follow-up study with the students to monitor their changes in perspective as they progress in their education[14,30].

Acknowledgements

We thank the Faculty of Economics students and the patients for their help in the pilot studies. Thanks to Olímpio Sebastião Juenta for translation of the questionnaires into Sena and Ndau; and to Aldina Maria Marques Ferreira, Beena Adathil Paily, Brigitte Krings-Ney, Geraldo Fernando Vunguire, Hiske Van Ravesteijn, Raffaella Dorsali and Sérgio Orlando Vilanculos Laita for their help with student training prior to administering the questionnaire. Thank you to Eduardo Selemane and medical students in years one to four for their help at the time of the study. We thank the anonymous reviewers for their time and specific comments which made this paper easier to read and understand. Special thanks to Lucia Deborah Mapimbiro for inputting the data, and to Dr. Bernard Groosjohan who was the Dean of the faculty at the time of the study.

References

1. Gilson L, Alilio M, Heggenhougen, K. Community satisfaction with primary health care services: An evaluation undertaken in the Morogoro region of Tanzania. *Social Science and Medicine*. 1994; 39:767-780.

2. Haddad S, Fournier, P. Quality, cost and utilization of health services in developing countries. A longitudinal study in Zaire. *Social Science and Medicine*. 1995; 40:743-753.

3. Grol R, Wensing M, Mainz J, Ferreira P, Hearnshaw H, Hjortdahl P, Olesen F, Ribacke M, Spenser T, Szécsényi J. Patients' priorities with respect to general practice care: An international comparison. *Family Practice*. 1999; 16:4-11.

4. Hurwitz B, V**a**ss A. What's a good doctor, and how can you make one? *British Medical Journal.* 2002; 325:667-668.

5. Ribeiro MMF, Krupat E, Amaral CFS. Brazilian medical students' attitudes toward patient-centered care. *Medical Teacher*. 2007; 29:e204-208.

6. Fones CS, Kua EH, Goh LG. 'What makes a good doctor?' – Views of the medical profession and the public in setting priorities for medical education. *Singapore Medical Journal*. 1998; 39:537-542.

7. Schattner A, Rudin D, Jellin N. Good physicians from the perspective of their practice. *BMC Health Services Research*. 2004; 4:26.

8. Herzig S, Biehl L, Stelberg H, Hick C, Schmeisser N, Koerfer A. [When is a doctor a good doctor? An analysis of the contents of statements by representatives of the medical profession] German. *Deutsche Medizinische Wochenschrift*. 2006; 131:2883-2888.

9. Cheraghi-Sohi S, Hole AR, Mead N, McDonald R, Whalley D, Bower P, Roland M. What patients want from primary care consultations: A discrete choice experiment to identify patients' priorities. *Annals of Family Medicine*. 2008; 6:107-115.

10. Holmes J. Good doctor, bad doctor: A psychodynamic approach**.** *British Medical Journal*. 2002; 325:722.

11. Smith A. Doctors and patients dance together. *British Medical Journal.* 2002; 325:723.

12. Walter C, Bury G, Leahy M. What makes a good doctor? A cross sectional survey of public opinion. *Irish Medical Journal*. 2003; 96:38-41.

13. Luthy C, Cedraschi C, Perrin E, Allaz AF. How do patients define "good" and "bad" doctors? *Swiss Medical Weekly*. 2005; 135:82-86.

14. Maudsley G, Williams EMI, Taylor DCM. Junior medical students' notions of a 'good doctor' and related expectations: A mixed methods study. *Medical Education*. 2007; 41:476-486.

15. Van Wieringen JCM, Harmsen JAM, Bruijnzeels MA. Intercultural communication in general practice. *European Journal of Public Health*. 2002; 12:63-68.

16. Schouten BC, Meeuwesen L. Cultural differences in medical communication: A review of the literature. *Patient Education and Counseling*. 2006; 64:21-34.

17. Haddad S, Fournier P, Machouf N, Yatara F. What does quality mean to lay people? Community perceptions of primary health care services in Guinea. *Social Science and Medicine*. 1998; 47:381-394.

18. Campayo JG, Broto CG, Buil B, Luengo MG, Caballero L, Collazo F. Attitudes of Spanish doctors towards immigrant patients: An opinion survey. *Actas Españolas de Psiquiatría*. 2006; 34:371-376.

19. Harmsen JAM, Bernsen RMD, Bruijnzeels MA, Meeuwesen L. Patients' evaluation of quality of care in general practice: What are the cultural and linguistic barriers? *Patient Education and Counselling*. 2008; 72:155-162.

20. Cass A, Lowell A, Christie M, Snelling PL, Flack M, Marrnganyin B, Brown I. Sharing the true stories: Improving communication between Aboriginal patients and healthcare workers. *Medical Journal of Australia*. 2002; 176:466-470.

21. Grace C, Begum R, Subhani S, Kopelman P, Greenhalgh T. Prevention of type 2 diabetes in British Bangladeshis: Qualitative study of community, religious, and professional perspectives. *British Medical Journal*. 2008; 337:a1931.

22. Unger JP, Van Dormael M, Criel B, Van der Vennet J, de Munck P. A plea for an initiative to strengthen family medicine in public health care services of developing countries. *International Journal of Health Services*. 2002; 32:799-815.

23. Jewkes R, Abrahams N, Mvo Z. Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science and Medicine*. 1998; 47:1781-1795.

24. Ferrinho P, Omar MC, Fernandes MJ, Blaise P, Bugalho AM, van Lerberghe W. Pilfering for survival: How health workers use access to drugs as a coping strategy. *Human Resources for Health*. 2004; 2:4.

25. Chapman RR. Endangering safe motherhood in Mozambique: Prenatal care as pregnancy risk. *Social Science and Medicine*. 2003; 57:355–374.

26. Igrega V. '*Why are there so many drums playing until dawn*?' Exploring the role of *Gamba* spirits and healers in the post-war recovery period in Gorongosa, Central Mozambique. *Transcultural Psychiatry*. 2003; 40:459-487.

27. Beninguisse G, De Brouwere V. Tradition and Modernity in Cameroon: The confrontation between social demand and biomedical logics of health services. *African Journal of Reproductive Health*. 2004; 8:152-175.

28. Chhaganlal K, van Jaarsveld I, Hoffmann K, Ramos MI, Krober M, de Hoop D. Cutaneous disorders in the "bairro Inhamudima" of Beira, Mozambique. *International Journal of Dermatology*. 2007; 46(S2):35-38.

29. Noden BH, Ferreira A, Gomes A. AIDS-related knowledge and sexual behavior among married and previously married persons in rural Central Mozambique. *SAHARA Journal*. 2009; 6:46-56.

30. Draper C, Louw G. What is medicine and what is a doctor? Medical students' perceptions and expectations of their academic and professional career. *Medical Teacher*. 2007; 29:e100-e107.

31. Driessen E, Van der Vleuten C. Matching student assessment to problem-based learning: Lessons from experience in a law faculty. *Studies in Continuing Education*. 2000; 22:235-248.

32. Green EC. *STDs and AIDS in Africa: Bridging the gap between traditional healing and modern medicine*. Boulder, CO: Westview Press; 1994.

33. Pfeiffer J. African Independent Churches in Mozambique: Healing the afflictions of inequality. *Medical Anthropology Quarterly*. 2002; 16:176-199.

34. Muula AS, Maseko FC. How are health professionals earning their living in Malawi? *BMC Health Services Research*. 2006; 6:97.

35. Willems S, De Maesschalck S, Deveugele M, Derese A, De Maeseneer J. Socio-economic status of the patient and doctor-patient communication: Does it make a difference? *Patient Education and Counseling*. 2005; 56:139-146.

36. Koehn PH, Swick HM. Medical education for a changing world: Moving beyond cultural competence into transnational competence. *Academic Medicine*. 2006; 81:548-556.

37. Meeuwesen L, Harmsen JAM, Bernsen RMD, Bruijnzeels MA. Do Dutch doctors communicate differently with immigrant patients than with Dutch patients? *Social Science and Medicine*. 2006; 63:2407-2417.

38. Callister LC, Getmanenko NI, Khalaf I, Garvrish N, Semenic S, Vehvilianen-Julkunen K, Turkina NV. Collaborative international research. *Journal of Continuing Education in Nursing*. 2006; 37:39-45.

39. Glew RH. Promoting collaborations between biomedical scholars in the U.S. and Sub-Saharan Africa. *Experimental Biology and Medicine*. 2008; 233:277-285.

40. Neville R, Neville J. What can health care professionals in the United Kingdom learn from Malawi? *Human Resources for Health*. 2009; 7:26.

41. Drain PK, Holmes KK, Skeff KM, Hall TL, Gardner P. Global health training and international clinical rotations during residency: Current status, needs, and opportunities. *Academic Medicine*. 2009; 84:320-325.