The Art of Inclusive Care: How do General Practitioners in Brussels Approach Diversity?

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1. ABSTRACT NL/EN

Nederlands Abstract

Titel:
De kunst van inclusieve zorg: Hoe gaan Brusselse huisartsen om met diversiteit?

Context:
Huisartsen in Brussel werken in een superdiverse stedelijke omgeving met patiënten met verschillende culturele, taalkundige, sociaal-economische, religieuze en gender-karakteristieken. Deze studie onderzoekt hoe huisartsen diversiteit ervaren en aanpakken om inclusieve en kwalitatieve zorg te leveren.

Onderzoeksvragen:
1) Hoe ervaren huisartsen in Brussel diversiteit, inclusief de bijbehorende voordelen en uitdagingen?
2) Hoe gaan huisartsen in Brussel om met specifieke aspecten van diversiteit, zoals de cultuur, afkomst, etniciteit, taal, religie, sociaaleconomische status, gender en seksuele geaardheid van hun patiënten?

Methode:
Voor deze studie werden semi-gestructureerde interviews afgenomen met 11 huisartsen werkzaam in Brussel. De data is geanalyseerd aan de hand van reflexieve thematische analyse met een focus op intersectionaliteit en gelaagdheid van diversiteit.

Resultaten:
Huisartsen ervaren diversiteit als een dynamisch, gelaagd en complex fenomeen dat persoonlijke en professionele groei stimuleert. Tegelijkertijd worden communicatiebarrières, uiteenlopende zorgverwachtingen en sociaaleconomische ongelijkheden ervaren als belangrijke uitdagingen. De aanpak van huisartsen wordt gekenmerkt door flexibiliteit, openheid, respect, het vermijden van bias en het verkrijgen van nauwkeurige informatie over hun patiënten. Waar nodig werken zij samen met andere professionals zoals tolken en maatschappelijke werkers.

Conclusie:
Diversiteit vormt een integraal onderdeel van de dagelijkse praktijk van Brusselse huisartsen. Door middel van patiëntgerichte benadering leveren zij inclusieve zorg. Praktische ervaring blijkt hier waardevoller dan theoretische training. Het onderzoek benadrukt dat een succesvolle aanpak van diversiteit niet alleen afhangt van individuele competenties van huisartsen, maar ook van structurele ondersteuning. Deze bevindingen onderstrepen de noodzaak van een geïntegreerde strategie waarin zowel artsen als het zorgsysteem gezamenlijk bijdragen aan inclusieve zorg voor alle patiënten.

Trefwoorden: Diversiteit, huisartsen, huisartsgeneeskunde, culturele competentie, cultureel sensitieve gezondheidszorg, taalbarrières, sociaaleconomische ongelijkheden, toegang tot zorg, Brussel, LGBTQIA+

English Abstract

Title:
The Art of Inclusive Care: How Do General Practitioners in Brussels Approach Diversity?

Context:
General practitioners (GPs) in Brussels work in a super-diverse urban environment, treating patients with diverse cultural, linguistic, socio-economic, religious, and gender characteristics. This study examines how GPs perceive and address diversity to provide inclusive and high-quality care.

Research Questions:
1) How do GPs in Brussels perceive diversity, including its associated benefits and challenges?
2) How do GPs in Brussels approach specific factors of diversity including the culture, origin, ethnicity, language, religion, socioeconomic status, gender and sexual orientation of their patients?

Methods:
Semi-structured interviews were conducted with 11 GPs practicing in Brussels. The data were analysed using reflexive thematic analysis, with a focus on intersectionality and the layered nature of diversity.

Results:
GPs perceive diversity as a dynamic, layered, and complex phenomenon that fosters personal and professional growth. At the same time, communication barriers, differing care expectations, and socio-economic inequalities are recognized as significant challenges. The GPs' approach is characterized by flexibility, openness, respect, avoidance of bias, and collection of accurate patient information. Where necessary, they collaborate with other professionals such as interpreters and social workers.

Conclusion:
Diversity is an integral part of the daily practice of GPs in Brussels. Through a patient-centred approach, they provide inclusive care. Practical experience is deemed more valuable than theoretical training in managing diversity. The study emphasizes that a successful approach to diversity depends not only on the individual competencies of GPs but also on structural support within the healthcare system. These findings highlight the need for an integrated strategy where both healthcare providers and the system contribute to inclusive care for all patients.

Keywords: Diversity, general practitioners, family medicine, cultural competence, culturally sensitive healthcare, language barriers, socio-economic inequalities, healthcare access, Brussels, LGBTQIA+

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4. INTRODUCTION AND BACKGROUND

Brussels, home to over 189 nationalities and with 60% of its population of foreign origin (BISA, 2023), is a melting pot of global migration and diversity. The city currently has the second-highest proportion of foreign-origin residents after Dubai (IOM, 2015). Beyond ethnic and cultural diversity, Brussels is shaped by several diversity factors, such as socioeconomic status, religion, language, gender, and sexual orientation, all influencing healthcare outcomes.

While Belgium's migration history dates back to the interwar period (Myria, 2015), post-World War II migration agreements sparked the most significant waves of immigration (Martiniello & Rea, 2003). Over time, Brussels has become a hub for international institutions, labour migrants, and undocumented asylum seekers, all of whom contribute to the city's complex healthcare landscape.

Sociologist Steven Vertovec's term "superdiversity" (2007) describes a heightened level of diversity. Hans Vandecandelaere (2022) further describes Brussels as "hyperdiverse," with migrants from various backgrounds merging into a complex mosaic of cultures, languages, and

identities. GPs must constantly adapt to this ever-evolving patient demographic to keep delivering tailored and high-quality healthcare.

With around 1,650 active GPs in Brussels, the city's healthcare system is divided into two associations: La Fédération des Associations de Médecins Généralistes de Bruxelles (FAMGB) for French-speaking GPs and Brusselse Huisartsenkring (BHAK) for Flemish-speaking GPs. This linguistic division adds to the complexity of addressing diversity in clinical practice.

As an immigrant from Poland who has lived in Brussels for three years, I observed with awe how GPs adeptly navigate these diverse consultations. This personal experience motivated my investigation into how GPs develop such adaptability and the strategies they use to meet the challenges of diversity in their daily practice.

The objective of this study is to understand how GPs in Brussels perceive and approach diversity. Two key research questions were formulated:

1. How do GPs in Brussels perceive diversity, including its associated benefits and challenges?

2. How do GPs in Brussels approach specific factors of diversity including the culture, origin, ethnicity, language, religion, socioeconomic status, gender and sexual orientation of their patients?

To answer these, I conducted semi-structured interviews with GPs, comparing their perspectives with Belgian and international studies. The findings offer insights into potential implications for practice and areas for further research.

5. LITERATURE STUDY

5.1 Objective and Methods of the Literature Study

The objective of the literature study preceding this qualitative study was to identify relevant background information pertinent to the two research questions.

Relevant articles were sourced through several databases, including the National Library of Medicine of the National Center for Biotechnology Information ('PubMed'), Belgian Centre for Evidence-Based Medicine ('Cebam'), Cochrane Library, KCE Belgian Health Care Knowledge Centre, EBMPracticeNet, and Google. Additional sources were retrieved through the 'related articles' function, as well as by following citations and references in selected papers. Moreover, consultations with experts led to the identification of further relevant materials.

The following Mesh terms/keywords were used in various combinations: 'primary care', 'general practitioners', 'family medicine', 'Belgium', 'Brussels', 'diversity', 'sociodemographic factors', 'culture', 'origin', 'ethnicity', 'culturally sensitive healthcare', 'language', 'socio-economic status', 'gender', 'LGBTQIA+', 'sexual orientation'.

The literature search included publications in English, Dutch, and French, with relevance determined based on titles and abstracts. Only articles published from 2004 onwards were considered, ensuring that the review focused on works no older than 20 years.

5.2 Results of the Literature Study

Research Question 1 - How do GPs in Brussels perceive diversity, including its associated benefits and challenges?

Diversity can be defined as *"the fact of many different types of things or people being included in something"* (Cambridge Dictionary, s.d.). It encompasses various characteristics such as culture, race, ethnicity, gender, disability, social class, socioeconomic status, sexual orientation, gender identity, spoken languages, and geographic origin (Togioka et al., 2023).

The diversity of patients can be enriching for healthcare professionals. Interacting with individuals from diverse backgrounds can enhance physicians' empathy and help them challenge their own biases and prejudices (Durieux-Paillard & Loutan, 2005). However, diversity can also present challenges in the patient-physician relationship, potentially impacting communication, the accuracy of diagnosis, counselling effectiveness, and the clarity and understanding of treatment options (Suurmond & Seeleman, 2006). Language and cultural barriers often contribute to mutual misunderstandings (Durieux-Paillard & Loutan, 2005). In case of language difficulties, physicians may simplify the therapeutic process or make decisions on behalf of the patient, rather than engaging in shared decision-making (Suurmond & Seeleman, 2006). Additionally, patients from different cultural backgrounds may express their symptoms in terms unfamiliar to the physician, complicating the process of understanding their ideas, concerns, and expectations (ICE) (Suurmond & Seeleman, 2006). Cultural differences in values and expectations regarding health, illness, and the roles of doctor and patient may further hinder communication (Suurmond & Seeleman, 2006), and multicultural settings can actually foster stereotyping (Durieux-Paillard & Loutan, 2005).

Research Question 2 - How do GPs in Brussels approach specific factors of diversity including the culture, origin, ethnicity, language, religion, socioeconomic status, gender and sexual orientation of their patients?

Family physicians generally emphasize their commitment to treating patients as individuals, transcending differences and avoiding discrimination. They often assert that optimal care is achieved by addressing sociocultural differences while avoiding the application of labels (Beagan & Kumas-Tan, 2009).

Culture, Origin and Ethnicity. GPs are expected to deliver culturally sensitive care (Juarez et al., 2006). Some studies suggest that culture is not always a focal point during consultations unless there is a breakdown in communication, at which point cultural differences become more prominent (Wachtler et al., 2006). Research indicates that physicians may exhibit less engagement in the relational aspects of care when interacting with ethnic minority patients, often due to implicit bias (Hall et al., 2015). This bias can manifest as reduced patient-centeredness, less friendly communication, greater verbal dominance, and lower levels of empathy and positive demeanour towards minority patients (Johnson et al., 2024). Conversely, better health outcomes in intercultural settings are linked to physicians who exhibit intercultural traits such as cultural empathy, emotional stability, flexibility, open-mindedness, and social initiative (van der Zee & van Oudenhoven, 2013).

Language. Various strategies exist for addressing language barriers, including physicians or team members learning additional languages, employing team members with diverse linguistic

backgrounds, using social interpreters or cultural mediators (in person, via video, or by telephone), utilizing translation apps, or relying on informal interpreters (Huis van het Nederlands, s.d.).

Religion. General practitioners exhibit four patterns in their attitudes toward providing spiritual care: embracing, pragmatic, guarded, and rejecting (Appleby, Wilson & Swinton, 2018). Spiritual dimensions are typically incorporated in specific contexts, such as palliative or mental health care (Puchalski et al., 2009).

Socio-economic status. Physicians tend to involve patients from lower socioeconomic backgrounds less in decision-making processes and provide them with fewer explanations than patients from higher socioeconomic backgrounds. Disparities in socioeconomic status between physicians and patients can lead to communication challenges, as these groups may hold differing views on healthcare and health (Deveugele et al., 2005).

Gender and sexual orientation. GPs are expected to address the comprehensive care needs of gender-questioning and transgender patients in the same manner as for any other patient, providing care that is open, respectful, sensitive, and free of bias (Royal College of General Practitioners, 2019).

6. METHODS

6.1 Study Design

This qualitative study aimed to explore how GPs in Brussels conceptualize and address diversity through in-depth, semi-structured interviews with 11 participants. A questionnaire was used to gather demographic and professional data. Both the interview guide and the questionnaire are provided in Appendix 1. The study was approved by the Research Ethics Committee (EC) of UZ/KU Leuven, with favourable advice MP027112 issued on 25 September 2023 (Appendix 2).

A pilot interview conducted on 13 October 2023 led to revisions, including shortening of the interview guide in order to remove overly detailed questions. The revised approach emphasized allowing participants to narrate their experiences and introduce relevant themes autonomously.

6.2 Participants

The inclusion criterion for participation was being a professionally active GP practicing in the Brussels-Capital Region. Purposive sampling was employed to ensure participant diversity in age, gender, origin, experience as physician, location of practice (different municipalities), type of practice, and whether or not the physician adhered to the NIHDI convention[1]. Regarding language, it was often difficult to categorize participants by a single mother tongue; therefore, respondents were distinguished based on their affiliation with either the Flemish-speaking (BHAK) or French-speaking (FAMGB) GP associations and by the number of languages spoken.

Several recruitment strategies were employed. The primary method involved distributing information about the study via the websites and newsletters of the Brussels GP associations. Contact details for potential participants were also obtained from the *Huis voor Gezondheid*, a

[1] NIHDI = National Institute for Health and Disability Insurance. NIHDI convention = the government-agreed fee structures without charging additional fees

Brussels-based network organization for Flemish-speaking healthcare professionals. GPs who expressed interest in participating received a detailed study description by email. Those who consented to participate proposed a convenient interview date. Before each interview, participants received and signed two copies of an informed consent form (ICF), available in either Dutch or English depending on the participant's preference, included in Appendix 3. Signed ICFs were digitized and securely stored on KU Leuven's OneDrive platform, while the paper copies were subsequently destroyed. Participants did not receive financial compensation for their involvement. None of the participants who originally expressed interest in participating and with whom the interviews have been taken, dropped out of the study in the later stages.

6.3 Privacy

Ensuring the privacy of participants was a primary concern throughout the research. Each interviewee was assigned a unique identifier linked to the corresponding interview transcript. This system of anonymization safeguarded their privacy and fostered an environment in which participants could openly express their views. Personal re-identification was further avoided by omitting the participants' names, surnames, and the names or addresses of their medical practices. Any additional personal information disclosed during the interviews that could potentially reveal their identity was anonymized.

6.4 Data Collection

The interviews were conducted in Brussels, Belgium, between 18 October 2023 and 11 March 2024. All interviews were led by me, Dr. Jan Lubomski, a male GP in training (HAIO), and took place face-to-face in the participants' own practices at a time convenient for them, except for one (Respondent 11), which was exceptionally conducted online via Microsoft Teams due to time constraints on the part of the interviewee. Conducting interviews in familiar environments was intended to provide a sense of security and help evoke relevant experiences from their clinical practice. To avoid interference, interviews were held in a private space, free from distractions and background noise, ensuring both privacy and the freedom for participants to express their thoughts openly. The researcher and the participant were the only people present at the time of the data collection. Each interview lasted between 40 and 60 minutes. Field notes were taken during interviews. No repeat interviews were carried out.

All interviews were audio-recorded and transcribed by the researcher. Upon transcription, the audio recordings were permanently deleted, and the transcriptions were securely stored in a password-protected folder on KU Leuven's OneDrive, accessible only to the researcher and the study's supervisor.

Following eleven interviews, I observed that recurring themes began to dominate the discussions, with fewer new ideas emerging, leading me to conclude that data saturation had been reached. As a result, I opted to cease further data collection at this point. Data saturation was also guided by the criteria in the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist, which was applied to this study (see Appendix 5).

6.5 Respondent Transcript Validation

Following the transcription process, respondent validation was carried out, a crucial step to uphold the credibility of the study (Charmaz, 2006). Each participant was sent the transcript of their interview via email and given four weeks to review and either confirm, reject, or modify the

content. Non-response within the allotted time was taken as an implicit confirmation of the transcript's accuracy. Of the eleven participants, two modified their transcripts, mainly for clarification purposes, while two confirmed their transcripts without any changes. The remaining seven did not respond, and their transcripts were considered fully validated. The respondents were not asked to provide feedback on the final findings of the study.

6.6 Data Analysis

The data obtained from the interviews were analysed by the researcher by the means of reflexive thematic analysis, a method aimed at systematically identifying, analysing and reporting themes (Braun & Clarke, 2006). My approach to data coding was description-focused which means I aimed for understanding the content and then describing the findings. This approach was appropriate given the richness of the data, which often included implicit meanings, reducing the need for extensive interpretation. For the analysis part, I chose the theoretical (deductive) approach where the research questions were clearly defined and served as themes. I used the NVivo software to assist in the coding process and to review themes. The visual thematic tree was included as Appendix 4.

7. RESULTS

7.1 Demographic Characteristics of the Participants

Interviews were conducted with eleven participants, whose demographic and professional characteristics are presented in Table 1. The sample exhibited considerable variation in terms of age, number of languages spoken, professional experience, and type of practice. Notably, ten out of the eleven participants (91%) were female. Seven participants (64%) were of Belgian origin, while the remaining four (36%) were of different national origins. Almost three-quarters (73%) were members of the Flemish-speaking GP association (BHAK). More than one-third (36%) of the respondents practiced in Anderlecht, with the remainder distributed across various municipalities in Brussels. A significant majority of participants (82%) adhered to the NIHDI convention.

Table 1. Characteristics of study participants: N =11

CHARACTERISTIC	N (%)
Age	
25–35	3 (27%)
36–45	3 (27%)
46–55	4 (36%)
56+	1 (9%)
Gender	
Female	10 (91%)
Male	1 (9%)
Origin	
Belgian	7 (64%)
Iraqi	1 (9%)
Irish	1 (9%)
Palestinian	1 (9%)
Polish	1 (9%)
GP circle	
BHAK (Flemish-speaking)	8 (73%)
FAMGB (French-speaking)	3 (27%)
Spoken languages	
2	1 (9%)
3	4 (36%)
4	3 (27%)
5	3 (27%)

CHARACTERISTIC – continued	N (%)
Experience as physician in years	
< 10	3 (27%)
10 - 19	3 (27%)
20 - 29	4 (36%)
≥ 30	1 (9%)
Municipality	
Anderlecht	4 (36%)
Brussels	2 (18%)
Etterbeek	1 (9%)
Jette	1 (9%)
Laeken	1 (9%)
Saint Gilles	1 (9%)
Schaerbeek	1 (9%)
Practice type	
Group practice of GPs	4 (36%)
Interdisciplinary practice	1 (9%)
Medical house (MM/WGC)	6 (55%)
Conventioned/Non-conventioned	
Conventioned	9 (82%)
Non-conventioned	2 (18%)

7.2 Perception of Diversity Among GPs in Brussels with its Benefits and Challenges

7.2.1 Perceiving Diversity: A Spectrum of Human Differences

All interviewed GPs perceive diversity as "differences between people," mentioning a wide range of factors including age, gender, sex, sexual orientation, socio-economic status, education level, having or not having children, skin tone, origin, physical differences, background, culture, residence, professional status, language, approach to health, and religion. Participant 1 illustrates an intersectional perspective on diversity:

> "(...) *like this Mikado game (*the pick-up sticks game - author's note*), where everything falls into place, and you yourself, as a person, are here at this point in the middle. Man, woman, gender, your socio-economic status, your culture, migration – all these factors constitute diversity for me"*.

Despite these differences, many highlight shared human experiences. Participant 5 states: *"In the end, we are all human beings, with a body and feelings. Different on the outside, similar on the inside."* Additionally, diversity is seen as dynamic, evolving over time: *"What is now may not be so tomorrow"* (Participant 6).

7.2.2 The Rewards of Practicing in a Diverse Setting

GPs in Brussels identify multiple benefits related to working in a diverse setting, top of the list being personal and professional growth. They find that interacting with varied cultural backgrounds challenges their assumptions, biases, and routines, fostering a broader perspective and greater empathy. Participant 3 describes the intellectual challenge of encountering different thought patterns and reasoning among patients:

> *"There are also quite a lot of intellectual aspects, such as dealing with people who think differently or reason in different ways, who are not like the patients we are used to. This forces you to question yourself and break out of your routine, prompting you to re-evaluate your habits and biases to ensure you are practicing good medicine. It also makes you pay attention to things you wouldn't notice if you had a more uniform patient population."*

Physicians appreciate the increased cultural awareness and sensitivity they gain from interacting with patients from backgrounds they might not otherwise encounter, had they not been working as a GP in Brussels, as Participant 3 reflects:

> *"I was able to discover a lot of things from a cultural point of view because I have patients who come from places I didn't know about and who also wanted to share that with me, (...) I had the opportunity to discover cultures like Moroccan or Turkish that I hadn't had the chance to discover elsewhere."*

Because of this cultural richness, several participants see working in Brussels as a substitute for travel. *"In the past, when I was a student, I travelled a bit, and now I think, that's no longer necessary, right? The world walks in here* (into the cabinet - author's note)*."* (Participant 4).

Communication skills are also enhanced, as managing diverse patients encourages practitioners to communicate effectively across cultural and linguistic barriers. Participant 4 emphasizes that what initially appears to be a communication difficulty can lead to deeper mutual understanding:

> *"But that is an advantage, I think, of all this mix of languages. You are always looking for what you understand and what I understand. I think it is really an advantage to always have to look for whether you understand me and whether I understand you."*

Professional clinical growth is another benefit, with GPs likening Brussels to an international medical experience. Participant 2 remarks:

> *"Many doctors want to go to Africa, South Asia, or South America to gain experience. But in Brussels, you can get that experience for free. Many cases, many diseases, social experience is also good for you, for the doctor."*

Concerning enhanced professional satisfaction and engagement, the interviewees describe their work with diverse patients as more stimulating and rewarding. Participant 10 notes that working previously with a non-diverse patient base felt "very dull". Now working in Brussels, diversity brings excitement and variety to their practice. The GPs express a general appreciation for the dynamic and engaging nature of a multicultural practice, which keeps the work interesting and fulfilling.

7.2.3 Challenges Posed by Superdiversity in Healthcare

Diversity poses significant challenges, with communication barriers being a significant obstacle in providing qualitative healthcare. Participant 11 notes that *"Language is a difficulty. If you cannot explain well what you want to explain or if the patient cannot really say what is wrong, then that is already an obstacle".* Adapting language often requires additional time and effort to ensure clarity in medical instructions. Involving a translator or cultural mediator during consultations can be administratively burdensome and time-consuming for general practitioners, especially in smaller practices where these professionals are not part of the interdisciplinary team. Understanding and interpreting non-verbal cues and nuances in a diverse patient population can be challenging. For instance, cultural differences in how pain is expressed, or the meaning of certain facial expressions can complicate the diagnostic process.

Diverse cultural backgrounds lead to varying beliefs and expectations regarding health. For instance, some patients may view obesity as a symbol of wealth or overlook non-symptomatic conditions, complicating the management of chronic diseases like diabetes. Preventive care, commonly prioritized in Western medicine, may be unfamiliar or undervalued by patients from other regions. Furthermore, patients may request specific tests or treatments familiar in their home countries (e.g., medical imagery, frequent antibiotics), which can clash with evidence-based practices. Consequently, this disparity can influence physicians' clinical decision-making and negatively affect patient satisfaction and adherence to treatment. Participant 8 gives an example of such a situation:

> *"I had a patient who had a history of tonsillitis in the past and when she'd had tonsillitis back in her country of origin, she had been given penicillin injections, I think it was intramuscular or intravenous? So, she came with a sore throat expecting a penicillin injection. (...) I certainly wasn't going to give her a penicillin injection because that would have been totally inappropriate. (...) But what I did in this situation, which I might have done otherwise, I actually prescribed oral antibiotics, a delayed prescription. I probably wouldn't have done that, but the fact that she came expecting an injection, it was then a kind of almost a compromise and meeting in the middle. So that was where actually the cultural expectation from having been seen and treated differently in a different system influenced my clinical practice, maybe not in the best way, but she was actually a bit upset that I wasn't going to give an injection."*

GPs also need to be aware of traditional and spiritual practices that may affect health, such as herbal remedies that could interact with prescribed medications. Religious traditions, such as fasting during Ramadan, also impact care management.

GPs also face significant administrative and practical challenges, especially when caring for patients from precarious settings or those with disabilities. The burden of completing extensive paperwork, coupled with misalignment and poor communication between different institutions as well as the administrative division of Brussels into 19 municipalities adds to the workload.

> *"We also have administrative problems with precarious or disabled populations. This leads to a certain amount of paperwork, which means that we have to fill out a lot more paperwork (...). This makes for an administrative load that can sometimes be burdensome. Especially since there's no alignment between administrations and administrations don't communicate with each other."* (Participant 3)

Some patients alternate between living in Belgium and their home countries, which leads to fragmentation of healthcare**.** This mobility often results in patients either stockpiling or lacking medications and missing regular follow-up appointments. The lack of an international health record system exacerbates these issues, compromising chronic disease management and overall health outcomes.

7.3 How GPs Approach Different Cultures, Origins and Ethnicities

7.3.1 Avoiding Assumptions and Bias: The Importance of Deep Inquiry

In a superdiverse environment, GPs emphasize the importance of obtaining precise, individualized patient information to avoid assumptions based on cultural or ethnic background. Particularly in Brussels, assumptions can be misleading; for instance, a patient of a particular ethnicity might be presumed to have a lower education level or refugee status, while in reality, they may hold a high-ranking diplomatic position. Participant 7 highlights the pitfalls of making health assessments based on appearance alone:

> *"It's important to know where they come from. Ethnicity on its own, it's not enough information. If you just look at the colour of the skin, you may assume that the patient has the same cardiovascular risk as an Afro-Caribbean person. But if they grew up somewhere else, you have to take that into consideration."*

Such insights underscore the need for thorough, context-aware inquiry. Accurate information gathering, effective communication, and critical listening are essential to avoid bias and support sound clinical reasoning.

7.3.2 Acknowledging Cultural Differences: A Dual Perspective

GPs in Brussels recognize the importance of acknowledging and respecting their patients' cultural practices and traditions. The concept of "live and let live" resonates deeply, reflecting a broader cultural sensitivity, recognizing that those differences do not imply superiority or inferiority, but simply diversity in perspectives and practices. Participant 5 notes:

> *"By the fact of being open to others and seeing, yes, they are also just people, they may have different ideas in that area, or they may do things that way, but that does not make them better or worse."*

Self-awareness of one's own cultural background is also crucial. Recognizing their own biases and upbringing allows GPs to avoid unconsciously projecting personal norms onto patients. As Participant 1 states:

> *"If you are not conscious of who you are, then you are going to think that everyone else is the same as you. If you don't know 'I'm like that, because I grew up like that' or 'that's been my thing, my life path', if you don't know that yourself, I don't think you're going to pay attention to that with your patient."*

Only with this sort of dual awareness, a physician can approach patients with empathy and openness, improving their ability to connect with and understand the patients' perspectives and, in turn, provide high-quality care.

7.3.3 Adapting the Approach to Diverse Cultural Contexts

To meet the needs of culturally diverse patients, GPs often adapt their approach. Expectations and trust in healthcare can vary significantly depending on the patient's background and familiarity with primary care. For instance, patients from regions without established primary care systems might have different expectations and levels of trust in GPs compared to those from regions with well-established primary care systems. These differences necessitate a flexible, adaptive approach, often requiring additional time for explanations, as Participant 11 remarks:

> *"So voila, it takes a lot of time because you have to explain a lot. Sometimes when my consultations run late, then I think of so much time and energy while you could actually just write medication, could say okay, voila... But that's maybe why that makes you a better doctor, because you put in the effort and I think that's why it is enriching".*

Through an adapted approach the physician is still able to help the patient, while respecting cultural nuances. Cultural sensitivity in communication is also essential. For instance, in cases where mental health or sexual health may be taboo, GPs may use indirect questions, such as, "How are you getting along with the children?" or "Are you getting enough rest?" rather than directly probing sensitive topics. Participant 10 describes a culturally sensitive approach to sexual health issues:

> *"When I tackle subjects that are a bit more complicated, no, in fact that are usually easy for me, like sexual health consultations, I have the impression that I also have to adapt the way I talk, the way I approach the situation. The same goes for vaccinations. We were talking about the HPV vaccine. How do you present it to a Moroccan mother with a 15-year-old child? It's different to a gay man working at the European Commission who is 30 and can afford the vaccine, for example."*

However, while adapting care, GPs also caution against "over-adapting," which can lead to avoiding relevant topics for fear of offending or due to personal biases. Participant 10 acknowledges this risk: *"I shouldn't censor what I ask just because patients give me the impression that it's forbidden."*

Respondents emphasize the role of patient-centred approach as a tool for working in a culturally diverse setting. By viewing each patient as an individual with a unique cultural background, one avoids a one-size-fits-all approach where the same medical or conversational strategy may not be effective or appropriate. Involving patients in decisions about their health fosters alignment with their cultural perspectives.

> *"Discuss with patients the options and how you support them and it helps you to accept patient's decision because in the end of the day the patient is responsible for their own care, but you have to really present to them options, pros and cons in a simple way so they can have a clear mind and they can choose the option that suits them."* (Participant 7).

Despite the need for tailored strategies, it can be helpful to start with a generic approach that transcends cultural boundaries. Participant 1 highlights the importance of adopting a universal attitude of respect towards patients, coupled with a flexible communication style that can be adapted as needed: *"You must have a 'generic' attitude, something that fits all cultures: respect for the patient, a way of communicating or asking questions.* This initial universal approach lays a

foundation for patient interactions, ensuring respect and understanding, which can then be customized based on individual cultural needs.

7.3.4 Practical Experience and Personal Traits: Building Competence in Diversity

While medical education increasingly incorporates training on diversity, cultural competence, and culturally sensitive care, many respondents question the necessity and effectiveness of extensive formal training. They argue that practical clinical experience in a diverse setting is more impactful. For example, one GP who worked in the Middle East and later in Belgium with Fedasil (Federal agency for the reception of asylum seekers) and Red Cross health centres feels well-prepared due to extensive experience with culturally diverse patients. Family medicine, with its focus on long-term follow-up and holistic approach, allows GPs to gather deep insights into patients' backgrounds, often beyond what is achieved in a single encounter. Personal experiences, whether from diverse social backgrounds, travel, or a multicultural family, also contribute to cultural competence. Furthermore, personal traits of physicians also play a role in being able to work in a diverse setting. Qualities such as a genuine interest in people, curiosity, good social skills, patience, a non-judgmental attitude, and open-mindedness are viewed as helpful. Those who possess these qualities and invest time in understanding their patients' backgrounds often find the experience personally enriching.

> *"So indeed, understanding how people function, their experiences, their origins, are things that interest me fundamentally. And so I invest energy and time but I get back as much energy as I have invested"* (Participant 3)

7.4 How GPs Approach Language Barriers

7.4.1 Adapting Communication and Language to Overcome Barriers

To overcome language barriers, physicians adapt their communication styles to enhance patient understanding. A common strategy is slowing down speech, as Participant 11 explains: "*I do try to adapt by talking less quickly*". Analogies also help simplify complex concepts; Participant 1, for instance, likens contraception to *"soldiers eating the enemy."* Visual aids such as images, videos, and illustrations further assist in explaining medical concepts. Participant 1 describes using these methods: *"And then also a lot of animation: showing images on the computer, I also have a book where I show everything, lots of pictures too.".* Despite the availability of many tools and services provided both by the government and various NGOs to overcome language barriers in healthcare, most physicians prefer to use personal resources like saved images or documents on their computers. Participant 4 notes that younger colleagues may rely more on newer translation tools:

> "*Specific websites myself actually little. I don't really know why. There are actually a lot of great tools, websites in different languages. I think my colleagues do that better. Especially the younger colleagues."*

When both the GP and patient speak the same language but in different dialects, GPs adapt accordingly. Participant 10 shares: *"Patients who speak Arabic don't necessarily speak the same dialect as I do, so I mix in some words from their dialect and for the rest, I tone down my own dialect a bit."* In extreme cases when there is no shared language and no third-party assistance, the communication becomes dominantly non-verbal. Participant 3 explains:

"With a patient who doesn't speak, we have to manage to figure out what's going on just with our hands, a stethoscope, and yes or no answers or gestures, which is sometimes not easy."

GPs differentiate between cases where minimal communication is sufficient, such as simple infections, and more complex issues like mental health, which require nuanced communication for effective care. Participant 8 highlights this challenge:

"If somebody has a cough or a sore throat or a sore foot, fine. But if there's a psychological component and there's a bit of nuance, then I feel that maybe I don't serve that patient as well as I would do in my native language".

Some practices address this by having multilingual staff, allowing patients to choose a physician they feel comfortable with. Participant 7 observes:

"*If they prefer to consult in, for example Polish with me, they probably will come with more difficult problems to me, but they don't mind seeing somebody else in English. I often see that happen in our practice."*

7.4.2 Using Third-Party Language Assistance

When language barriers limit communication, GPs turn to third-party assistance, with intercultural mediators regarded as particularly effective for bridging both linguistic and cultural gaps. Participant 4 describes the benefit of working with a permanent Turkish mediator:

"We have a Turkish intercultural mediator here, and I find that to be a real asset. They work here permanently. I also learn a lot from them; it's not just translation but also guidance about cultural nuances."

Professional interpreters are another resource, accessible through various institutions and associations. Participant 9 finds these services relatively easy to arrange: "For non-native speakers, there are many agencies to get interpreters... I know how to arrange for an official interpreter." However, the time and administrative requirements can make interpreters challenging to incorporate, especially in private practices. GPs that provide services within ONE or Kind en Gezin (government-run child and family services) have more consistent access, as administrative staff can book interpreters in advance.

In unplanned situations, family members often serve as unofficial interpreters, though GPs highlight the drawbacks. Untrained family members may misinterpret medical terms, and emotional biases can affect translation quality. Using children as interpreters is especially discouraged, both for accuracy and to avoid disrupting their education. Participant 4 explains:

"And then sometimes there is still someone from the family who comes along to interpret. If that's two adults, then it's okay in itself. With children we are very strict here, we hardly have that anymore, and we actually refuse that. Then we say, look, you have to come back and we will arrange an interpreter and your child will go to school. Because that's not the right way…"

Despite these limitations, unofficial interpreters, particularly adult family members, can provide convenient, immediate assistance, at the same time keeping the family informed and engaged in

the patient's care. GPs acknowledge their role while stressing the importance of professional services whenever possible.

Technology comes often as first help when it comes to language barriers. With the development of translating tools such as Google Translate or DeepL and the ease of its use on mobile and stationary devices, GPs often reach for them in situations where no other third-party help is available, being still aware of the limitations, including the risk of inaccurate translations and a lack of human interaction.

7.4.3 Multilingual Teams as the Desirable Solution

Beyond adapting communication or relying on external resources, many GPs view multilingual teams as the ideal solution, the best possible situation being the physician and the patient sharing a language they are both comfortable in. Participant 1 highlights the benefit: *"Language is obviously an advantage, if you can speak your patient's language."* In practices with other multilingual staff, receptionists and other team members often assist with both administrative and informal interpreting needs, all while adhering to confidentiality standards, as noted by Participant 1:

> "*People from the reception who come here to interpret. They are not actually trained for that, but they are reception staff so medical confidentiality and so on, we do that."*

Moreover, multilingualism among staff fosters a welcoming atmosphere for patients. The more languages a team can accommodate, the more inclusive the environment.

> *"We're lucky enough to have quite a few languages, so we have Dutch, French, English and German. So that's quite a lot, and we have other colleagues who also understand and speak a little bit of other languages too."* (Participant 3)

In Brussels, where approximately 108 languages are spoken, multilingualism is a distinct advantage. Participant 4's remark captures this linguistic diversity, where they perceive speaking 3 languages as few: *"I only speak three languages fluently: Dutch, French, and English. I know two words of Spanish and one word of German, so that's not much."* Many of the GPs express a keen interest in learning foreign languages, with the diversity of their patient population acting as a strong motivator. Participant 3 notes, *"I'm starting to learn Italian because I have many Italian patients."*

For effective interprofessional collaboration, GPs also consider language compatibility when referring patients to specialists. As Participant 3 states, *"I've been referring patients to colleagues who I knew spoke the patient's language."*

7.5 How GPs Approach Religious Differences

7.5.1 Respecting Religions and Their (Medical) Implications

The interviewed GPs express a commitment to respecting their patients' religious beliefs, regardless of the specific faith. Participant 5 encapsulates this sentiment concisely: *"So I say, believe whatever you want."* For some physicians, religious beliefs do not pose a challenge as long as patients uphold universal values. As Participant 11 notes, *"The beliefs, they don't bother me at all. I think as long as there is respect for everyone, for science, then there is no problem."* This respect extends to accommodating the religiously influenced medical preferences of patients. Examples

provided by the participants include situations involving blood tests, gynaecological examinations, and abortion:

> *"I once had a patient, she did not want to take blood. Who felt that was not correct. I told her that it is very important for her so she has to decide, and that one said "no, I will wait".* (Participant 2)

> *"Another example about religion is that some people do not want a gynaecological examination if they are not married. I cannot use speculum because she is not married, she is still a virgin."* (Participant 2)

> *"Abortion is something that is difficult, especially with Muslims, but then I also think, yes, that is actually not a difficulty for me. You discuss it, but you don't impose anything, and that's just people's beliefs as well."* (Participant 4)

On the other hand, several physicians mention how one should also be aware of the influence of one's own religious background. One needs to be aware of it and its possible implications but not let these convictions influence the medical care one provides. Otherwise, it might compromise the care for the patient by not respecting their religious framework, as Participant 7 explains:

> *"(...) and you try to force your idea as to how good it will be for the patient, but then you may do more harm than good. Because of your beliefs, the patient's care is compromised (...)."*

7.5.2 The Question of Inquiry: To Ask or Not to Ask?

When discussing whether it is important to ask about patients' religious beliefs, GPs express differing views. Some believe it is essential to include this in intake consultations, as it may affect the care provided. Others prefer not to ask unless the patient volunteers the information, citing the complexity of religions and the difficulty in understanding their impact on healthcare without specific knowledge.

7.5.3 Religion as a Supportive Tool in Patient Care

For religious patients, GPs sometimes incorporate spiritual or philosophical concepts to provide comfort, particularly in mental and emotional health situations like depression, burnout, or grief. Participant 3 explains the value of this approach:

> *"(...) it helps to unblock a lot of things at a psychological level. We've also seen it quite clearly, that in problems of anxiety disorders or burn-out or certain types of depression, we call on philosophy a lot, and philosophy isn't psychology, it's spirituality, so you don't necessarily have to look to Islam, Christianity or Buddhism or anything else. Sometimes you just have to ask yourself, what do people believe?"*

This approach is particularly useful in palliative care, as Participant 4 shares:

> *"But at that stage of life, if you don't have that spiritual dimension, I think people miss that. I think at a time like that it's nice if you can have some kind of comfort, like it's God who is going to take care of me after all I'm putting my fate in his hands now, and I find that beautiful and also reassuring."*

The social aspect of spiritual life also offers support during tough times. Participant 1 highlights the role of religious communities in helping one another: *"Spiritual, but that is also social networking of helping each other, of being there for each other, of going to church together."* Some physicians use religious sayings, relevant to the patient's beliefs, to console them, as Participant 1 says: *"What I also occasionally mention in my consultation are proverbs from the Quran, for example, that I like 'Allah will not give you anything that you cannot bear.'"*

7.6 How GPs Approach Socio-Economic Disparities

7.6.1 The Critical Role of Socio-Economic Awareness

GPs emphasize the importance of understanding a patient's socio-economic status as a factor in providing quality healthcare. Participant 7 highlights: "*Socioeconomic status has been proven and is evidence based that it has an impact on patients, health and outcomes"*.

Patients rarely volunteer this information, that is why it is important for GPs to ask directly. Participant 5 notes: *"Patients do not always dare to say it, you have to explicitly ask about it"*. Some GPs include questions regarding socio-economic status in their intake consultations. Participant 7 explains why:

> *"It's part of the interview that you have with the patient. It's equally important as their past medical history or surgeries they had or family history, allergies, socioeconomic background is very important."*

Some GPs, however, choose not to ask about socio-economic status directly. Instead, they employ a strategy of gathering insights gradually, through observation and the ongoing therapeutic relationship, or by interpreting data such as insurance status. Observation involves noting patient appearance, behaviour, and education level. Over time, GPs become more familiar with their patients' employment, origin, challenges, and living conditions. In Belgium, individuals with lower incomes are entitled to an "increased allowance" (NL: recht op verhoogde tegemoetkoming, RVT), which provides higher reimbursement for healthcare services. Physicians can see this status in their electronic records, offering additional socio-economic context. However, relying solely on observation can lead to assumptions as Participant 4 admits: *"Yes, that's true, how do I know? Yes, you often think you see that. Yes, you try not to judge, but you judge, don't you? Yes, you do."*

House visits provide a unique opportunity to gain deeper insight into a patient's socio-economic background, but the current trend of reducing home visits, which is common in many GP practices, may limit this way of gathering knowledge about patients.

7.6.2 Navigating External Support Systems for Socio-Economic Challenges

In a developed country like Belgium, addressing the socio-economic struggles of patients does not fall solely on the shoulders of physicians. In practices serving a significant proportion of financially disadvantaged patients, social assistants play an essential role. They are generally employed by medical houses (NL: wijksgezondheidcentra), which cater to financially disadvantaged populations by providing care covered entirely by health insurance. These medical houses operate on a flat-rate financing system that allows for hiring non-medical staff, unlike solo or small group GP practices, which typically lack such support. Navigating Brussels' social support system can be complicated for both physicians and patients alike, as Participant 5 explains:

"Mutuality, invalidity, disability, OMCZ/CPAS, minimum wage, medical card, red card, green card, child benefit, IRIS care, PHARE, and then it's kind of interesting, do they themselves know what they have? Often they don't. And do they themselves know what they are entitled to?"

Dutch-speaking GPs in Brussels face additional challenges in securing support for non-French-speaking patients within a predominantly French-speaking social welfare system. Participant 9 gives an example of this:

*"I don't find that very clear in Brussels either. It is also all in French which is all well and good if the patient is French-speaking, I do want to adapt, but if the patient is not French-speaking, is that a giant hurdle just to get an appointment at the CPAS (*author's note: Belgian public centre for social welfare*), for example."*

7.6.3 Providing Equitable Care While Adapting Treatment Options

Despite the socio-economic diversity of their patients, GPs in Brussels emphasize the importance of treating all patients equally, with respect and adherence to shared humanitarian values. However, they acknowledge that certain treatment options may need to be adjusted based on the patient's financial circumstances. This includes prescribing practices, as Participant 11 explains:

"All I might do is think carefully about what I prescribe, depending on whether they have the CPAS medical card (author's note: this card covers costs of necessary healthcare services of people unable to afford medical care) *or not. Because then maybe I won't prescribe unnecessary things that I might prescribe to someone else, like a cough syrup or something. Yes, you know that could be €10 and €10 is a lot."*

When referring patients to specialists, understanding the local network of conventioned and non-conventioned providers is critical, as the latter may be financially challenging for patients. However, Participant 7 emphasizes the importance of avoiding assumptions: *"It becomes judgmental if you assume that a patient who comes from a poor background doesn't want to seek help in the private care sector."*

Some general practitioners assist patients in less favourable financial situations by offering pro bono consultations. Non-conventioned physicians might reduce consultation fees in these cases. However, due to the complexity of modern healthcare systems, offering free or cheaper consultations alone does not address the full scope of needs that might include medical imaging, medications, or referrals to specialists, which then remain unaddressed. Participant 1 explains:

"But pro bono, that is only the time of the consultation if the problems are more serious then you have to arrange for a health card but not everyone wants a health card."

7.7 How GPs Approach Gender and Sexual Orientation

7.7.1 Acceptance and Normalisation

GPs in Brussels commonly work with LGBTQIA+ patients, adopting an accepting and supportive approach where sexual orientation does not affect the patient-doctor relationship. As Participant 8 states, *"It doesn't in any way influence what I do and I don't treat them* (LGBTQIA+ patients) *differently."* Physicians aim to create a non-judgmental and non-stigmatizing environment, with

the underlying message of unconditional acceptance: regardless of one's orientation, it is regarded as entirely natural. As Participant 5 emphasizes, *"You are allowed to start feeling what you want for who you want and how that makes you feel, that's absolutely normal".*

For transgender patients, GPs proactively support their identity, often updating their records to reflect the patient's new name or gender, even if administrative changes are pending. This gesture aims to respect and affirm the patient's identity. Participant 7 gives an example of how they do it in practice: "*But due to GDPR I cannot just kind of flag it up, so I put a little code for myself to remember that I need to call the patient with a different name".*

7.7.2 Inquiring About Sexual Orientation

For most GPs, asking about sexual orientation is not standard practice unless clinically relevant, such as when the patient may belong to a higher-risk group for certain conditions. While not typically part of standard intake, some advocate for including sexual orientation as a routine question to further normalize its discussion. Participant 6 supports this practice, suggesting: *"I asked that they ask this question directly at intake, like you ask of what is your height, what is your weight, what is your sexual orientation?"*.

7.7.3 Medical Considerations for LGBTQIA+ Patients

LGBTQIA+ patients often require specialized care for health concerns associated with their identities. The GPs interviewed demonstrate awareness of these needs, including the higher incidence of sexually transmitted infections (STIs) within the MSM (men who have sex with men) community and mental health challenges prevalent among transgender individuals. Their knowledge is informed and up to date on the specific vulnerabilities faced by these populations. Participant 3 emphasizes the importance of recognizing mental health complexities:

> *"(...) the minority stress of LGBTQIA+ communities, which puts them at greater risk of substance abuse, alcoholism and anxiety-depressive disorders. This is not insignificant, because we often tend to think that gay equals HIV, but in fact gay equals suicide. Suicide is the leading cause of death in these populations, it's mental health, not STIs. So these are things we need to be aware of."*

8. DISCUSSION

This study explored how general practitioners (GPs) in Brussels perceive and navigate the complexities of diversity in their clinical practice, particularly in a superdiverse environment shaped by varying cultural backgrounds, languages, religions, socio-economic statuses, genders, and sexual orientations. Using Reflexive Thematic Analysis (Braun & Clarke, 2006), the study revealed the ways in which GPs approach and adapt to this diversity, as well as its perceived benefits and challenges. Reflexivity, which acknowledges the researcher's role in interpreting the data, was instrumental in uncovering nuanced insights about the practices and attitudes of GPs, shaped in part by the researcher's own experiences in the field.

8.1 Understanding Diversity and Its Impact

In addressing the first research question - how GPs perceive diversity and its associated benefits and challenges - it became apparent that participants viewed diversity as an integral part of their

professional experience. Consistent with the work of Vertovec (2007) on superdiversity, the GPs in this study viewed diversity as encompassing much more than just ethnicity or nationality; they saw it as a complex, multi-layered and intersectional phenomenon involving among others the cultural background, socio-economic status, language, religion, gender, and sexual orientation. Intersectionality is a theoretical framework rooted in the fact that human experience is jointly shaped by multiple social positions which cannot be adequately understood by considering those factors only independently (Bauer et al., 2021). Importantly, participants recognized diversity as a dynamic and evolving phenomenon, which demands a flexible, individualized approach in practice. This perspective supports findings from Beagan & Kumas-Tan (2009), who highlight the importance of an individualized approach in culturally diverse healthcare settings to reduce bias and foster equitable care.

The GPs appreciated diversity for the depth it added to their practice, describing the experience of caring for diverse populations as both personally fulfilling and professionally rewarding. Interactions with patients from different backgrounds challenged their own biases, broadened their cultural awareness, and enhanced their communication skills. These perspectives resonate with Suurmond and Seeleman's (2006) assertion that diversity in clinical settings fosters professional growth by challenging practitioners to critically evaluate their assumptions and biases. This reflective process, integral to working with diverse populations, plays a key role in developing empathy—a cornerstone of patient-centered care (Beagan & Kumas-Tan, 2009).

However, diversity also posed significant challenges. GPs reported difficulties in maintaining clear communication with patients who speak different languages. The lack of a shared language was described by GPs as a persistent issue, sometimes resulting in misdiagnoses or compromised treatment plans. This echoes Durieux-Paillard & Loutan's (2005) observation that language barriers can lead to misunderstandings and that in some cases, GPs may simplify the treatment process to avoid communication breakdowns, reducing patient autonomy. Moreover, GPs reported that the administrative burden of organizing interpreter services or relying on informal interpreters (e.g., family members) often complicates the consultation process. Cultural diversity also presented challenges related to differing expectations regarding healthcare. Several GPs noted that patients from certain cultural backgrounds may have specific expectations about medical treatment, such as a preference for antibiotics or diagnostic tests, which may not align with evidence-based practices. This dynamic often forced GPs into difficult conversations where they had to balance respecting the patient's beliefs with providing medically appropriate care. This echoes findings by Wachtler et al. (2006), who suggest that cultural differences can complicate clinical decision-making, especially when patients hold strong beliefs about treatment that diverge from evidence-based medical practices.

8.2 Approaching Diversity in Practice

In terms of how GPs approach specific dimensions of diversity, such as culture, origin, ethnicity, language, religion, socioeconomic status, gender and sexual orientation, the data revealed a commitment to providing an individualized approach, taking into account each patient's own factors.

Many GPs in this study emphasized the importance of avoiding assumptions based on a patient's ethnicity or origin. Clinical decisions based on ethnic stereotypes can lead to inaccurate diagnoses or inappropriate treatment plans. This perspective aligns with research by Hall et al. (2015) and

Beagan & Kumas-Tan (2009), which underscore the dangers of implicit bias in clinical settings. GPs in this study stressed the need for deep inquiry and personalized care, rather than relying on generalizations about a patient's background. This aligns with Charles et al. (2006), who highlight the value of asking open-ended, patient-centred questions as a way to understand each patient's unique health beliefs and expectations.

The pursuit of culturally sensitive care doesn't necessarily entail acquiring knowledge of specific cultures. Given the super-diverse nature of Brussels, attempting to attain knowledge of all cultures would be an impractical endeavour. That is why also in this case GPs apply a more generic approach with a focus on individualized care which reflects the broader movement toward patient-centred care in diverse settings (Juarez et al., 2006).

Several participants expressed the view that diversity training was less effective than hands-on experience in building the necessary skills to manage a diverse patient population. They argued that direct interaction with patients from different cultural backgrounds provided a more comprehensive education than formal training programs. This view aligns with findings by Harmsen et al. (2005), who noted that practical experience is often more impactful than structured cultural competency training. On the other hand, other studies also showed that education interventions (involving both patients and doctors) on the topic of cultural differences and intercultural communication can result in improvement in both mutual understanding and perceived quality of care (Harmsen et al., 2005a), (Rosenberg et al., 2006).

One of the most persistent challenges for GPs in Brussels was managing language barriers. Participants frequently reported that they had to adapt their communication styles to ensure that patients understood medical advice. This often involved speaking more slowly, using simpler language, or resorting to visual aids. Some reported using analogies or metaphors to explain medical concepts in simpler terms. Others mentioned the importance of non-verbal communication, particularly in consultations where no common language existed. When more complex issues were involved, such as mental health concerns, the lack of a shared language could significantly hinder the quality of care. This challenge is echoed in the broader literature, where language barriers have been shown to reduce the quality of doctor-patient communication, leading to misunderstandings or misdiagnoses and thus to poorer health outcomes (Al Shamsi et al., 2020).

When third party help was needed, GPs reported relying on cultural mediators and interpreters, with the former being the preferred solution. That is because intercultural mediation involves activities not only aimed at minimizing the negative impacts of language barriers, but also socio-cultural differences, and ethnic tensions in healthcare settings (Federal Public Service Health, Food Chain Safety and Environment, 2017). This preferred choice is supported by literature that echoes that through the added values of intercultural mediation, it facilitates the therapeutic relationship between health providers and patients (Qureshi, 2011). Nevertheless, the administrative burden and time constraints often made it difficult to incorporate professional help into consultations, which further aligns with findings by Qureshi (2011), who noted that intercultural mediation in healthcare settings can be time-consuming but is essential for bridging communication gaps. Some GPs opted to use family members as interpreters, though this posed quality and ethical dilemmas, particularly when children were involved. This practice, while convenient, has been criticized in the literature for its potential to introduce inaccuracies and emotional strain (Rosenberg et al., 2006). Despite all the resources and strategies mentioned

above, respondents emphasized that optimal care is achieved when the physician or at least another member of the medical team and the patient share a common language, opting for multilingual teams.

The GPs in this study demonstrated a high level of respect for their patients' religious beliefs, understanding that faith can play a critical role in health decisions. This respect extended to areas like fasting, dietary restrictions, and even preferences for certain treatments, such as declining blood transfusions due to religious beliefs. Some GPs used religious sayings or referenced spiritual beliefs when discussing difficult topics such as grief or end-of-life care. Puchalski et al. (2009) have highlighted the value of integrating spirituality into medical care, particularly in palliative settings, as it can provide significant comfort to patients facing critical health challenges.

However, balancing religious beliefs with medical best practices was not always straightforward. Some GPs mentioned that they had to navigate delicate situations where religious beliefs conflicted with recommended medical interventions, such as vaccinations or gynaecological exams for unmarried women. In these instances, the GPs again employed a patient-centred approach, discussing options with patients while respecting their autonomy. This approach is supported by the findings of Charles et al. (2006), who noted the importance of shared decision-making in religiously sensitive situations.

Socio-economic status played a critical role in shaping how GPs approached patient care. Several GPs reported adjusting their treatment plans based on the patient's financial situation, a practice that has been documented in the literature on socio-economic health disparities (van Ryn & Burke, 2000, Deveugele et al., 2005). For example, some GPs would prescribe cheaper alternatives to medication or refer patients to specialists who adhered to government-set fee structures. While these strategies helped mitigate some of the financial barriers patients faced, GPs acknowledged that they were not a comprehensive solution. Structural inequalities in healthcare access remained a significant issue, particularly for patients who were uninsured or lacked the necessary documentation to receive state assistance.

The GPs also highlighted the role of social services in supporting financially disadvantaged patients. In certain cases, they worked closely with social assistants to help patients navigate the complex welfare system in Brussels. However, they pointed out that accessing these services could be particularly challenging for non-French-speaking patients, further complicating care for those from immigrant backgrounds. This mirrors scientific findings by Martiniello & Rea (2003) regarding bureaucratic obstacles in diverse urban environments. Research by Missinne et al. (2019) highlighted specifically the administrative challenges faced by both GPs and patients when navigating Brussels' fragmented healthcare and social support systems.

The interviewed GPs displayed a high level of sensitivity toward LGBTQIA+ patients, emphasizing an approach of acceptance and normalization. Most reported that sexual orientation and gender identity did not affect the care they provided, as they sought to create a non-judgmental environment in which all patients felt comfortable discussing their health concerns. This approach aligns for example with the Royal College of General Practitioners (2019) guidelines, which emphasize the importance of non-discriminatory care. However, several GPs acknowledged that they had to adapt their communication styles when discussing sensitive issues such as sexual health, particularly with patients from cultural backgrounds where such topics were taboo. This

required a patient-centred approach, as GPs had to find ways to broach these subjects without causing discomfort.

However, GPs also recognized the unique healthcare challenges faced by LGBTQIA+ individuals, particularly regarding mental health. Participants noted the high rates of mental health issues such as depression and suicide within the LGBTQIA+ community, a finding supported by Schiel et al. (2022), who emphasized the importance of addressing the psychological well-being of these populations. GPs were also mindful of the need for specific medical attention in certain groups, for example regular STI testing for the MSM population (men who have sex with men). GPs reported taking proactive steps to ensure that identities of transgender patients were respected in clinical settings, even if the patient had not yet completed their legal transition. This practice is supported by existing guidelines on transgender healthcare, which advocate for the use of preferred names and pronouns in medical records (Royal College of General Practitioners, 2019).

8.3 Implications of the Study

The study highlights the need for GPs in a superdiverse context for a flexible, patient-centred approach that accommodates the needs of patients. A significant implication is the critical importance of fostering cultural humility and openness in clinical encounters, which enables GPs to approach each patient without relying on cultural assumptions or stereotypes. This practice aligns with Schouten & Meeuwesen (2006), who argue that cultural sensitivity enhances trust and patient satisfaction. For GPs, this means prioritizing individualized care, where a nuanced understanding of each patient's socio-cultural and personal context guides individual clinical decisions.

The study underscores the need to adopt a holistic, patient-centred approach when addressing socio-economic disparities. By adjusting treatment options and incorporating social support mechanisms, GPs can mitigate the impact of financial constraints on patient adherence to treatment plans. However, this also calls for more integrated care pathways, where GPs collaborate with social workers, psychologists, and other healthcare professionals to address the social determinants of health. The broader implications of this approach are consistent with international recommendations on integrating social care into medical practice, as highlighted by Jackson & Gracia (2014). The flat-rate financing system used by medical houses (NL: wijkgezondheidscentra) could serve as a model for expanding non-medical support staff, such as social assistants, within general practices that serve vulnerable populations. Expanding this model could relieve the burden on GPs while ensuring that patients receive the comprehensive support they need.

The findings also suggest that GPs should remain vigilant about the potential biases they bring to clinical encounters. The importance of avoiding assumptions about patients based on their cultural or socio-economic backgrounds is critical to providing unbiased care. In the context of continuous professional development, healthcare organizations could offer workshops on implicit bias, as proposed by Hall et al. (2015), to help GPs recognize and mitigate unconscious biases that could impact their clinical decisions. Such workshops could include role-playing exercises or simulated patient interactions in culturally diverse scenarios to provide hands-on learning experiences. Furthermore, incorporating feedback from diverse patient groups into professional development programs could give GPs valuable insights into their own practice and foster a cycle of continuous improvement in cultural competence.

To better prepare future GPs for their role in a superdiverse society, it is recommended that academic programs emphasize the development of soft skills over theoretical diversity training. Respondents highlighted that practical experience is paramount, underscoring the importance of fostering empathy, avoiding bias, and enhancing skills in listening, obtaining accurate patient information, and demonstrating openness and curiosity. Integrating experiential learning opportunities, such as internships in diverse communities or interactive workshops simulating multicultural scenarios, could effectively equip students with the tools to navigate the complexities of diversity. Additionally, structured reflection sessions and mentorship from experienced practitioners can help students internalize these skills and build the adaptability needed for inclusive, high-quality care in a superdiverse setting.

GPs could benefit from certain practical tools, such as culturally sensitive aids, to address specific challenges, like language barriers or discussions of taboo topics in culturally appropriate ways. The findings from Al Shamsi et al. (2020) and Harmsen et al. (2005) further underscore the importance of investing in these tools and related services to reduce communication-related errors in patient care.

In terms of LGBTQIA+ inclusivity, the study suggests that inclusive practices, such as respecting patients' chosen names and pronouns, should be standardized across healthcare settings. Policymakers might consider issuing official guidelines to support LGBTQIA+ inclusivity in healthcare, as recommended by the Royal College of General Practitioners (2019). Such guidelines could include best practices for patient intake procedures, record-keeping, and sensitivity training. This approach would foster a healthcare environment where all patients feel respected and seen, potentially improving health outcomes by reducing the stress associated with minority status (Schiel et al., 2022).

At a policy level, this study underscores the need for robust structural support to address the linguistic, cultural, and socio-economic diversity present in Brussels and similar metropolitan areas. Access to interpreter services emerged as a particularly urgent requirement, given that language barriers are a major obstacle to effective care. Expanding interpreter services in healthcare facilities and ensuring that these services are readily accessible to all healthcare providers, not only those in institutional settings, is crucial. Policymakers could consider subsidizing or mandating interpreter availability in private and public healthcare settings alike, as supported by Al Shamsi et al. (2020), who identify language access as fundamental to equitable healthcare. The findings also indicate a need to streamline access to social welfare services, particularly for non-native speakers who may struggle to navigate a predominantly French-speaking system in Brussels.

The study opens avenues for future research, particularly in exploring how systemic barriers—such as the availability of interpreter services and the impact of socio-economic status on health outcomes—affect patient care in Brussels and similar urban settings. Future studies could examine the long-term impact of policy changes aimed at improving cultural competence and language services on patient satisfaction and health outcomes. Additionally, comparative studies between Brussels and other superdiverse cities could provide further insights into best practices for healthcare delivery in multicultural environments.

Finally, future research could explore the psychological impact of working in superdiverse environments on healthcare providers. Given that GPs reported both professional enrichment and

challenges in managing diversity, understanding the mental health implications for practitioners could guide the development of supportive measures to prevent burnout and enhance job satisfaction. This research could benefit from a mixed-methods approach, combining quantitative surveys with qualitative interviews, to capture a comprehensive view of GPs' experiences and needs.

8.4 Strengths and Weaknesses of the Study

One of the key strengths of this study lies in its focus on the underexplored area of superdiversity in primary care within Brussels, a city with exceptional cultural and linguistic diversity. By specifically examining how GPs adapt their practices to meet the needs of such a varied population, this research addresses a gap in the literature on culturally competent healthcare in multicultural urban contexts. This adds valuable insight into the nuanced approaches GPs take in navigating cultural, religious, linguistic, and socio-economic challenges, offering an evidence base that can inform both local policy and international best practices.

Another strength of this study lies in its reflexive approach, which allowed for a deep engagement with the data and the identification of themes that resonate both with the researcher's experiences and the wider literature. Reflexive thematic analysis acknowledges the active role of the researcher in shaping the analysis, ensuring that the findings are not simply a product of the data but are also influenced by the researcher's professional insights. This is particularly relevant given the researcher's background as a GP in training in Brussels, which provided valuable context for interpreting the interviews. As Braun and Clarke (2013) argue, reflexive engagement enables the researcher to produce a rich, nuanced analysis, while saliency analysis ensures that significant themes are captured even if they do not appear frequently.

In-depth semi-structured interviews provided further methodological strengths. This approach allowed the establishment of a comfortable rapport between the researcher and participants, enabling more honest discussions on sensitive topics such as cultural and socio-economic diversity in healthcare. The relatively small number of participants who have been interviewed in their own workplace facilitated more genuine and detailed insights, with the GPs able to discuss their experiences and views in considerable depth. This aligns with existing literature, which suggests that qualitative interviews, while not generalizable in a statistical sense, can yield highly detailed accounts that are crucial for understanding complex phenomena (Braun & Clarke, 2013).

Another strength is the diversity of the participants achieved by purposeful sampling and thus including GPs from various linguistic backgrounds, types of practices, and different areas of Brussels. This allowed for a wide range of perspectives, trying to reflect the superdiversity of the city. The use of participant validation—where respondents had the opportunity to review their interview transcripts—further strengthened the credibility of the data by ensuring that participants' views were accurately represented.

While qualitative research often benefits from providing some contextual details about participants to better frame their statements, such as "Participant 12, a 56-year-old female GP working in a medical house in Molenbeek," this study opted for a stricter level of confidentiality. All participants are simply referred to as 'Participant X' to ensure complete anonymity, minimizing any possibility of identification.

However, this study also has several limitations. One of the primary concerns is the issue of researcher bias. Given the researcher's professional role as a GP in training in Brussels, there was an inherent risk of confirmation bias, where the researcher might have been more inclined to interpret the data in ways that confirmed pre-existing beliefs or expectations. While measures were taken to mitigate this risk, such as triangulating data across time, locations, and participant profiles, the subjective nature of qualitative research cannot fully eliminate the influence of the researcher's perspectives. The process of reflexivity, while offering rich engagement, may have also led to an over-reliance on the researcher's personal interpretation of the data, potentially overshadowing alternative interpretations.

Another limitation concerns the study's sample size and geographic focus. While the in-depth nature of qualitative interviews provided detailed insights, the small sample size limits the generalizability of the findings. The focus on Brussels, while relevant to the research questions, also means that the study's conclusions may not be applicable to GPs working in less diverse or rural settings. The GPs who chose to participate may also have been more familiar with or comfortable discussing the concept of diversity, potentially skewing the findings towards more positive or well-considered views on the subject. Those GPs who are less comfortable with the concept of diversity or who struggle more in addressing it in their practice may have been less inclined to respond to the study invitation, introducing a potential selection bias.

The concept of data saturation, a debated topic in qualitative research, was considered throughout the data collection process. One of the key problems with this approach is the fact that in thematic analysis, the researcher performs the analysis only once all the interviews have been completed (Tight, 2023). That means that it is not possible to fully determine the saturation during the interview phase.

In terms of methodological challenges, the process of conducting and analysing in-depth interviews is time-consuming and labour-intensive. Transcribing the interviews, coding the data, and organizing themes required significant effort, particularly given the rich and complex nature of the data collected. This time-intensive process also introduced the possibility of researcher fatigue, which may have influenced the depth of analysis. Moreover, as this was the researcher's first qualitative study, the lack of prior experience in conducting interviews and thematic analysis may have influenced the thoroughness of the coding process or the interpretation of nuanced responses, despite careful theoretical preparation.

Respondent bias may have influenced the results. While steps were taken to ensure anonymity and encourage honest responses—such as removing identifiable information from the transcripts—there remains a risk of social desirability bias, where participants may have given answers they believed were more socially acceptable or aligned with what the researcher wanted to hear. This is a common challenge in qualitative research, particularly when sensitive topics such as cultural competence or socio-economic disparities are discussed. However, by keeping the interviews anonymous and obtaining consent for the transcripts post-interview, the study sought to mitigate this bias as much as possible.

Lastly, the study does not capture the experiences of patients themselves, who could provide additional insights into the effectiveness of GPs' diversity-responsive practices. Patient perspectives would offer a valuable counterpoint to the GP-reported practices, helping to evaluate whether patients feel respected and understood in diverse healthcare settings. Future studies

might include patient feedback through interviews or surveys, which could provide a fuller picture of patient-GP interactions in superdiverse contexts.

Despite these limitations, the measures taken to reduce both respondent and researcher bias, including the triangulation of data, participant validation, and anonymity, enhance the credibility of the findings.

9. CONCLUSION

9.1 Summary of Findings

In summary, this study found that general practitioners (GPs) in Brussels perceive diversity as a multifaceted, evolving phenomenon shaped by the city's unique superdiverse context. GPs view their work in a multicultural environment as both challenging and rewarding, with significant personal and professional growth as a key benefit. Navigating this diversity broadens their perspectives, enhances empathy, and improves cultural and communication skills. However, they also face distinct challenges, such as language barriers, administrative complexities, and different beliefs expectations regarding health and healthcare. Addressing them requires adaptable patient-centred approaches while avoiding assumptions and biases. This approach not only facilitates more accurate diagnoses and treatment plans but also helps to strengthen the doctor-patient relationship, contributing to better health outcomes.

9.2 Addressing Research Questions

The research questions were addressed by examining how GPs in Brussels perceive and respond to diversity in their practices. The study demonstrated that GPs are highly aware of the complexities of diversity and actively work to adapt their approaches based on individual patient needs. They adapt their communication styles to overcome language barriers, with intercultural mediators and multilingual staff identified as optimal solutions. They carefully avoid assumptions by gathering precise information and respect cultural, religious, and socio-economic contexts. GPs foster inclusive, supportive environments and demonstrate awareness of specific health risks affecting LGBTQIA+ patients. By detailing the strategies and challenges in managing diversity, the study offers a comprehensive overview of how GPs practice inclusivity and adaptability in a superdiverse urban setting. Overall, the GPs in this study exhibited a commitment to providing individualized care that transcended cultural, linguistic, and socio-economic differences. Their capacity to tailor care to the unique needs of each patient demonstrates their overarching dedication to patient-centered care, emphasizing respect, empathy, and effective communication.

9.3 Overall Significance

These findings are significant because they reveal the essential role of adaptability, cultural humility, and patient-centeredness in providing equitable healthcare in a multicultural society. The rewards GPs experience—such as enhanced empathy, broader clinical skills, and professional satisfaction—highlight the intrinsic value of working in diverse environments. At the same time, the challenges GPs face underscore the need for structural support, including expanded interpreter services, streamlined administrative processes, and policies that facilitate access to social services for non-native speakers and economically disadvantaged patients. This study

contributes to the literature on diversity-responsive healthcare by demonstrating how practical, experiential learning shapes the effectiveness of diversity management in primary care. It also points to the broader implications for healthcare systems worldwide, suggesting that patient-centred approaches rooted in respect, flexibility, and empathy are crucial for equitable care in multicultural settings.

9.4 Final Thoughts

In conclusion, it is crucial to recognize diversity as a dynamic and intersecting set of factors that impact healthcare delivery in complex ways. This study highlights the importance of a flexible, individualized approach that enables GPs to adapt effectively to the varying needs of a superdiverse population. By understanding and respecting each patient's unique background, GPs can provide care that not only addresses clinical needs but also honours personal beliefs, cultural practices, and social contexts. This research underscores the value of diversity in enriching medical practice and enhancing empathy, and it calls for continued efforts to support healthcare providers in delivering inclusive care. Such efforts are essential to ensuring that primary care services in multicultural urban settings, such as Brussels, are accessible, equitable, and effective in addressing the full spectrum of patient needs.

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11. APPENDICES

11.1 Appendix 1 - Interview Guide and Questionnaire

INTERVIEW GUIDE

Master-na-master in family medicine - master's thesis

"How do GPs deal with Brussels diversity?"

Jan Lubomski

(Whenever the interview was conducted in English or French, the guide was a literal translation of the English version).

INTERVIEW QUESTION LIST

1. What is diversity for you?

    - How do you feel about it?

    - What are your views on it?

2. How do you encounter diversity professionally and privately?

    - With what kinds of diversity?

    - In what circumstances does it happen?

3. What positive and negative points do you see about diversity?

4. How do you deal with diversity?

    - What effect does it have on your work?

    - Does diversity affect your therapeutic relationships? Your private relationships?

    - Do you see any impact of this on healthcare outcomes?

5. How do you deal with:

    - different cultures?

    - languages?

    - your patient's origin?

    - your patient's religious beliefs?

    - your patient's socio-economic status?

    - your patient's gender?

    - your patient's sexual orientation?

ADDITIONAL INFORMATION ABOUT THE PARTICIPANT (QUESTIONNAIRE):

- name and surname:

- age:

- gender:

- experience as a doctor (number of years after graduation):

- origin:

- spoken languages:

- municipality where the practice is settled:

- type of practice: solo practice / group practice of general practitioners / interdisciplinary practice / Medical House (WGZ/MM)

- convention: conventioned / not conventioned

11.2 Appendix 2 - Research Ethics Committee Study Approval

Our reference: MP027112
Your reference: Master's thesis study: Hoe gaan huisartsen met de Brusselse diversiteit om?
Leuven, 25-09-2023

DEFINITIVE FAVOURABLE ADVICE

Dear Professor Professor Geert Goderis
Dear Jan Lubomski

The Research Ethics Committee UZ/KU Leuven hereby confirms that there are no objections to conducting the proposed study, as it was described in the protocol. After a thorough ethical review, the Commission found no concerns regarding the study. The study was approved on 25-09-2023

Het betreft een prospectieve kwalitatieve studie waarbij aan de hand van diepte interviews 10 a 20 Brusselse huisartsen zullen bevraagd worden omtrent hun visie over en hun omgang met de diversiteit in Brussel hoofdstad. Het protocol is goed opgesteld. Informatiebrief en ICF zijn ok. Er zijn geen bezwaren tegen de studie. Wel nog een opmerking: Is er nagedacht over de representativiteit van de studie? Als interviews enkel in het Frans afgenomen worden kunnen enkel Frans sprekende huisartsen bevraagd worden en worden anderstalige huisartsen uitgesloten van de studie.

The Committee has no objection to the project provided that the data are handled confidentially and there is compliance with the Belgian legislation concerning privacy. The Research Ethics Committee UZ/KU Leuven reminds the principal investigator/promotor of the study of their responsibilities with regard to the privacy of personal / patient details, when in contact with living persons, patients, and / or contained within electronic medical records, including the correct implementation by employees and students.

This letter of no objection concerns the submission of 05-09-2023v and is given for the duration of the Master's thesis of the student(s) concerned. Any amendment to the protocol will invalidate this advice. In that case, you must submit an amendment for advice to the committee that previously approved your file must be submitted.

The Committee confirms that they work in accordance with the ICH-GCP principles (International Conference on Harmonisation Guidelines on Good Clinical Practice), with the most recent version of the Helsinki Declaration, and with applicable laws and regulations.

The Committee confirms that in case of a conflict of interest, the members concerned have not participated in decision regarding the study.

Yours sincerely,

Prof. dr. Minne Casteels
President / Chairperson
Research Ethics Committee UZ/KU Leuven

Prof. dr. Pascal Borry
President / Chairperson
Education-Support Committee for Medical Ethics KU Leuven

11.3 Appendix 3 - Informed Consent Form (ICF)

Title of the study: Hoe gaan huisartsen om met de Brusselse diversiteit?

(How do General Practitioners deal with Brussels' diversity?)

Research organisation: KU Leuven

Ethics committee: *EC Research UZ/KU Leuven*

Researchers: *Jan Lubomski, student of master-na-master huisartsgeneeskunde,*
jan.lubomski@student.kuleuven.be,
Geert Goderis, promotor, geert.goderis@kuleuven.be

I Information necessary for your decision to participate

Introduction

You are invited to participate in a study on exploring the ideas, beliefs and approach to diversity of the patient population by Brussels general practitioners. In order to help you decide whether or not to take part in this study, please take the time to review the following information for participants so that you can make an informed decision. This is called "informed consent".

We ask you to read the following pages of information carefully. If you have any questions, please contact the researcher.

This document consists of essential information that you need to make your decision, your written consent and any attachments that contain more details about certain parts of the basic information.

If you are participating in this study, you should know that:

Ø This study was drawn up after evaluation by the Ethical Committee (EC) Research UZ/KU Leuven.

Ø Your participation is voluntary; there can be no question of coercion. Your signed consent is required for participation. Even after you have signed, you can let the researcher know that you want to stop your participation without giving any reason.

Ø The information collected within the framework of your participation is confidential. Your anonymity is guaranteed when the results are published.

Ø If you would like additional information, you can always contact the researchers.

Objectives and conduct of the study

This study has following objectives:

- To examine the ideas and beliefs of Brussels GPs about diversity.

- To assess whether Brussels GPs consider their patient population to be diverse.

- To deepen the knowledge about dimensions of diversity within family medicine.

- To learn more about the challenges faced by general practitioners in Brussels in the context of a diverse patient population.

- To learn more about how Brussels general practitioners improve their skills related to working in a diverse setting.

We invite you to participate in this study because you are an active GP whose practice is located in the Brussels Capital Region. This is the only inclusion criterium. Approximately 10-20 GPs will participate in this study.

We would like to explore the influence of the super-diverse Brussels environment on your work. In addition, we are curious to know how you deal with this diversity yourself. The researcher will ask you to participate in an interview that probes your ideas, beliefs and experiences around diversity. Participation in the interview will take about 40-60 minutes of your time and the interview will be conducted in your practice, at a time that would be most convenient for you. Only audio recordings will be made during the interview. The recordings will be used afterwards for transcription only. After transcription, all audio recordings will be destroyed. After the interview you will fill out a short questionnaire with some personal data. These will then be coded in the process of pseudonymization. The study will not include any personal data by which you could be identified.

Description of the risks and benefits

You do not benefit from participating in this research; however, you can, by sharing your knowledge and/or experiences, contribute to qualitative treatment within family medicine in a diverse setting.

Withdrawal of your consent

It is up to you to decide whether you want to take part in the study. Participation is voluntary. If you decide not to participate, you do not need to do anything else. You do not have to sign anything. You also do not have to say why you do not want to participate.

If you do participate, you can always change your mind and still stop, even during the study. You do not have to give a reason for this.

If you wish to participate in this study, we would like to ask you to:

Ø Cooperate fully to ensure the proper conduct of the study.

Contact

If you require additional information, but also in case of problems or if you have any concerns, you can contact the investigator (Jan Lubomski) via (jan.lubomski@student.kuleuven.be) and the principal investigator (professor Geert Goderis) via the telephone number +32 16377280 (werkuren) or via e-mail (geert.goderis@kuleuven.be).

If you have any questions about your rights as a participant in the study, please contact the Ethical Committee Research UZ/KU Leuven (ec@uzleuven.be; 016 34 86 00 (working days between 10 and 11 a.m.)).

Title of the study: Hoe gaan huisartsen om met de Brusselse diversiteit?

(How do General Practitioners deal with Brussels' diversity?)

II Informed consent form

Participant

I declare that I have been informed of the nature, purpose, duration, potential benefits and risks of the study and that I know what is expected of me. I have read the information document and its annexes.

I have had sufficient time to think and, if desired, to consult with a person of my choosing.

I was able to ask all the questions that came to my mind and I received a clear answer to my questions.

I understand that my participation in this study is voluntary and that I am free to discontinue my participation in this study. I don't have to give a reason for this and I know that there will be no consequences to me for this decision.

I understand that, during my participation in this study, data will be collected about me and that the researchers will ensure the confidentiality of these data in accordance with the relevant European and Belgian legislation.

I would like / I do not want to be informed about the general research results of the study (choose one).

I have received a copy of the participant's information and informed consent.

Surname, first name, date and signature of the participant

Researcher

I, the undersigned (Jan Lubomski) researcher, declare to have provided orally the information required for this study and to have provided a copy of the information document to the participant.

I confirm that no pressure has been exerted on the participant to agree to participate in the study and I am willing to answer any additional questions that may arise.

I confirm that I work in accordance with the ethical principles set out in the "Helsinki Declaration", the "Good Clinical Practice" and the Belgian Law of 7 May 2004 on Experiments on the Human Person.

Surname, first name, date and signature of the investigator

Title of the study: Hoe gaan huisartsen om met de Brusselse diversiteit?

(How do General Practitioners deal with Brussels' diversity?)

III Additional information

1: Additional information on the protection and rights of the participant

Ethical Committee

This study was evaluated by an independent ethics committee, namely EC Research UZ/KU Leuven, which issued a favourable evaluation. The ethics committees have the task of protecting the persons participating.

Under no circumstances should the positive evaluation of the Ethics Committees be considered as an incentive to participate in this study.

Voluntary participation

Do not hesitate to ask any questions you may have before signing. Take the time to talk to a trusted person about it, if you wish.

You have the right not to participate in this study or to stop this study without having to give a reason, even if you have previously agreed to participate in this study. Under no circumstances will your decision adversely affect you.

If you agree to take part in this study, sign the consent form. The researcher will also sign this form and thus confirm that he has given you the information necessary for this study. You will receive the copy intended for you.

Costs related to your participation

You will not be reimbursed for your participation in this study. However, your participation will not impose any additional costs on you.

Confidentiality Guarantee

Your participation in the study means that the researchers collect and use data about you for research and in the context of scientific and medical publications.

Your data will be processed in accordance with the European General Data Protection Ordinance (AVG) and the Belgian legislation on the protection of individuals with regard to the processing of personal data. KU Leuven is the data controller of your data.

You have the right to ask the researchers what information they have collected about you and what it is used for in the context of the study. You have the right to access this information and to have it corrected if it is incorrect[1].

The researchers are obliged to treat these collected data confidentially.

This means that they undertake never to disclose your name in the context of a publication or a conference and that they will encrypt your data (your identity will be replaced by an identification code in the study). The personal data transferred does not include a combination of elements that make it possible to identify you[2].

The (coded) research data can be passed on to Belgian or other regulatory authorities, to the ethics committees, to other researchers and/or institutions that collaborate with the sponsor. This is always done in encrypted form.

The commissioner of the study undertakes to use the data collected only for the purposes of this study.

If you withdraw your consent to participate in the study, the encrypted data already collected before your withdrawal will be kept. This guarantees the validity of the study. No new data will be passed on to the commissioner of the study.

For studies that do NOT take place in UZ Leuven: If you have any questions about how we use your data or if you want to exercise your right of access, correction, or possible suspension of the further processing, you can always contact your researcher at the following contact address: jan.lubomski@student.kuleuven.be. If you have any particular concerns or wish to lodge a complaint afterwards, you can contact the KU Leuven privacy team at privacy@kuleuven.be

To conclude, if you have a complaint concerning the processing of your personal data, you can contact the Belgian supervising authority which monitors compliance with the basic principles of the protection of personal data:

Gegevensbeschermingsautoriteit (GBA)

Drukpersstraat 35,

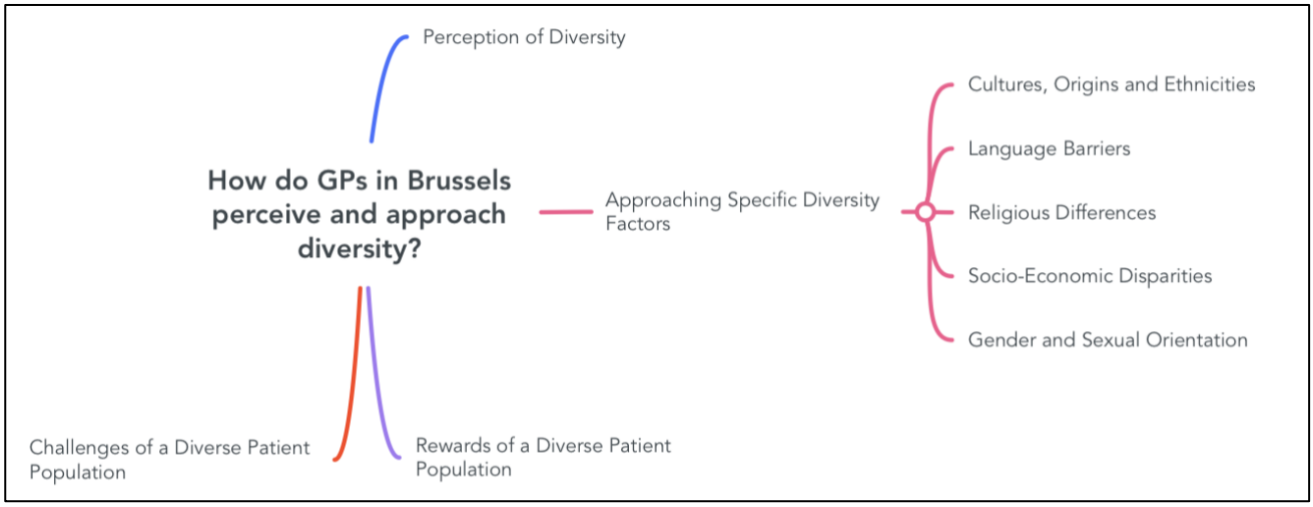
1000 Brussel

Tel. +32 2 274 48 00

e-mail: contact(at)apd-gba.be

Website: www.gegevensbeschermingsautoriteit.be

11.4 Appendix 4 – Visual Thematic Tree



11.5 Appendix 5 – COREQ checklist

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity *Personal Characteristics*		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	**12**
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	**12**
3. Occupation	What was their occupation at the time of the study?	**12**
4. Gender	Was the researcher male or female?	**12**
5. Experience and training	What experience or training did the researcher have?	**31**
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	**9-10**
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	**42-43**
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	**42-43**
Domain 2: study design *Theoretical framework*		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	**13**
Participant selection		

10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	**9**
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	**9-10**
12. Sample size	How many participants were in the study?	**10**
13. Non-participation	How many people refused to participate or dropped out? Reasons?	**10**
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	**12**
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	**12**
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	**9-11**
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	**9, 39-40**
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	**12**
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	**12**
20. Field notes	Were field notes made during and/or after the interview or focus group?	**12**
21. Duration	What was the duration of the interviews or focus group?	**12**
22. Data saturation	Was data saturation discussed?	**12, 30-32**
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	**12**
Domain 3: analysis and findings *Data analysis*		
24. Number of data coders	How many data coders coded the data?	**13**

25. Description of the coding tree	Did authors provide a description of the coding tree?	**46**
26. Derivation of themes	Were themes identified in advance or derived from the data?	**13**
27. Software	What software, if applicable, was used to manage the data?	**13**
28. Participant checking	Did participants provide feedback on the findings?	**12**
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	**13-24**
30. Data and findings consistent	Was there consistency between the data presented and the findings?	**25**
31. Clarity of major themes	Were major themes clearly presented in the findings?	**24-27**
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	**24-27**