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THE IMPORTANCE OF TEACHING INTERCULTURAL COMMUNICATIVE COMPETENCE IN ENGLISH FOR SPECIFIC PURPOSES COURSE IN EUROPEAN MEDICAL SCHOOLS

In the 21 century, population in Europe has become diverse more than ever before and this trend is expected to continue in the future. Consequently, European health care systems and providers will need to reflect on and respond to patients' varied perspectives, values, beliefs, and behaviors about health and wellbeing. The significance of communication in health care is, therefore, of great importance because effective health care delivery relies on clear and effective communication which is in turn an essential element in every form of medicine and health care between all of the individuals who are involved: patients, physicians, and other health care professionals. If, in any way, communication between health care providers and patients is not clear, the entire medical treatment process can be problematic and clear communication hindered when the participants come from different cultures. For this reason, intercultural communicative competence in health care has emerged in part to address the factors that may contribute to racial/ethnic disparities in health care. Hence, intercultural communicative competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behavior, including tailoring delivery to meet patients' social, cultural, and linguistic needs. In simple terms, the word "intercultural" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of different racial, ethnic, social, or religious groups. "Communication" refers to the art and technique of using words effectively to impart information or ideas. "Competence" implies the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by communities. So, the ultimate goal is a health care system that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or language proficiency. Moreover, it is precisely interculturally competent communication that serves as bedrock of the physician communication competence in interacting with patients because it insists on contextually suitable communication behaviors designed to foster maximum physician sensitivity to culturally different patients (Betancourt, Green and Carrillo, 13). Thus, to become interculturally competent, health care providers must: (1) be made aware of the impact of social and cultural factors on health beliefs and behaviors; (2) be equipped with the tools and skills to manage these factors appropriately through training and education; and (3) empower their patients to be more of an active partner in the medical encounter (Betancourt, Green and Carrillo, 10). Health institutions can achieve this through:

1. Cross-cultural training as a required, integrated component of the training and professional development of health care providers;

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2. Quality improvement efforts that include culturally and linguistically appropriate patient survey methods and the development of process and outcome measures that reflect the needs of multicultural and minority populations; and
3. Programs to educate patients on how to navigate the health care system and become an active participant in their care (Betancourt, Green and Carrillo, 9).

In 2000, to show the importance of culturally competent communication in health care, the Liaison Committee on Medical Education² (LCME) introduced the standard for cultural competence according to which the faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. In the same year Flores, Gee and Kastner conducted research on teaching cultural issues in American and Canadian medical schools. The authors contacted the deans and/or directors of courses on cultural issues at total of 126 U.S. and 16 Canadian medical schools. Using a cross-sectional telephone survey, they asked whether each school had a course on cultural sensitivity or multicultural issues and, if so, whether it was separate or contained within a larger course, when in the curriculum the course was taught, and which ethnic groups the course addressed. The response rates were 94% for both U.S. (118) and Canadian (15) schools. Very few schools (U.S. = 8%; and Canada = 0%) had separate courses specifically addressing cultural issues. Schools in both countries usually addressed cultural issues in one to three lectures as part of larger, mostly preclinical courses. Significantly more Canadian than U.S. schools provided no instruction on cultural issues (27% versus 8%; $p = 0.04$). A few schools taught about the specific cultural issues of the largest minority groups in their geographic areas: only 28% and 26% of U.S. schools taught about African American and Latino issues, respectively, and only two thirds of Canadian schools taught about either Asian or Native Canadian issues. Only 35% of U.S. schools addressed the cultural issues of the largest minority groups in their particular states. The authors concluded that most U.S. and Canadian medical schools provide inadequate instruction about cultural issues, especially the specific cultural aspects of large minority groups.³

Language teaching has always inevitably meant, in fact, teaching both “language and culture” because knowledge of other culture is as important as proficiency in their language and such knowledge is dependent on foreign language teaching (Byran; Byran and Sarries). Hence, the purpose of teaching intercultural communicative competence in compulsory ESP course in European medical schools is to make the learners conscious about any evaluative response to culturally different others. The role of the instructor is, therefore, to not only teach but also to help students see relationships between their own and other cultures, help them to become interested and curious about otherness and become aware of their own culture. To develop the cross-cultural dimension in the European lecture halls, the ESP instructor should design pointers for students that will make them grasp the idea of intercultural competence in health care. So, the following points in teaching intercultural communicative competence should not be, therefore, considered as definite because this area is very wide and it should allow each language instructor to make his/her own set of instructional priorities within the context. According to Byram, Grobkova, Starkey (13-15) the instructor should:

1. Teach basics of cultural competency and ground rules of intercultural communication. This is an initial step in preparing students (as future health care providers) for interaction with people of other cultures.
2. Enable them to understand and accept people from other cultures as individuals with other distinctive perspectives, values and behaviors.
3. Help them to see and understand that such interaction is an enriching experience (by giving a lot of examples).

² Liaison Committee on Medical Education (LCME) is a nationally recognized authority for medical education programs leading to the MD (Medical Doctor) degree in the US and Canadian medical schools.

³To the authors' knowledge, such research has not been conducted in European Medical Schools until now, so we do not have relevant data to compare. Nevertheless, intercultural communicative competence has been taught as an integral part of ESP curriculum at the University of Nis Medical School in Serbia since 2003.



4. Teach students the knowledge of social processes (such as assimilation and de-marginalization of certain cultural groups).
5. Introduce comparing and contrasting in class. They are very important because students need to be able to see how misunderstandings can arise and how to resolve them. By comparing and contrasting two or more cultures side by side and seeing how each might look from the other perspective, students can see how unintentional misunderstandings occur in both spoken and written language.
6. Focus on skills of discovery and interaction. This means the ability to acquire new knowledge of a culture and cultural practices and the ability to operate knowledge, attitudes and skills under the constraints of real-time communication and interaction.

The students should learn how to overcome stereotypes about different cultures and look at the patient as an individual whose qualities are yet to be discovered, rather than as a representative of an externally ascribed identity of other cultural, racial or national group. In other words, the students must take a proactive stance and develop sensitivity to the role culture plays in health care. The students should constantly be challenged in class to simultaneously examine their own cultural biases (if any) as they learn about other cultures and different health belief systems.⁴ The students learn that all cultures have beliefs about illness and health that derive from the way they perceive the world and that each culture creates unique patterns of beliefs and perceptions about health and illness which in turn influence how illness is recognized, to what it is attributed, how it is interpreted and how and when health services are sought (Samovar and Porter; Cooper *et al.*; Gwyn; Klopff and McCroskey). The students learn not to approach health care from a single cultural perspective, but must learn to treat patients from other cultures in a culturally competent manner because cultural barriers can greatly influence the healing process (Ting-Toomey and Chung). Finally, every student should understand that health care delivery anywhere on this planet could be hindered by cultural diversity, lack of knowledge about diversity and inability to communicate effectively which altogether lead to false diagnosis. So, in order to avoid the aforementioned and achieve an objective of optimal health care for all people instead, health care providers must be interculturally competent. This means that they should primarily:

- a) Understand the foundation of intercultural competence: curiosity and openness, empathy, readiness to suspend disbeliefs about other cultures and beliefs about one's own.
- b) Demonstrate willingness to assess the impact of one's own culture, assumptions, stereotypes, and biases on the ability to provide culturally competent care and service.

⁴Health belief systems are divided into three major categories: 1) *the supernatural health care tradition* stems from a belief system in which the world is predominated by supernatural forces. Followers of this tradition firmly believe in the existence of sorcery, magic and evil spirits while the fate of the world and all of those in it depend upon God, gods or other supernatural forces of good or evil. This tradition is popular in some parts of Southeast Asia, Vietnam, the Caribbean and some Latino countries. Furthermore, some of the oldest and most widespread superstition regarding the cause of illness is the evil eye or the belief that someone can cause harm by gazing or staring at another person. Belief in the power of the evil eye still exists in many parts of the world such as Southern Europe, the Middle East and North America 2) *the holistic tradition* is grounded in the belief that a whole is made up of interacting parts. Similarly, an individual is a whole made up of interdependent parts, which are known as physical, mental, emotional and spiritual. As a result, if one part is not functioning at its best, it affects all of the other parts of that person because all parts are in constant interaction with everything in the surrounding environment. This approach is embraced by Asian people (Filipinos, Koreans, Japanese and Southeast Asians), Africans, Haitians and Jamaicans), and, 3) *the scientific tradition* is rooted in the objective diagnosis and scientific explanation of disease. It is an evidence-based approach to illness and other bodily disorders that relies on procedures such as laboratory tests to verify the presence and diagnosis of disease. Since it is based on rational thinking it very often ignores psychosocial aspects of illness such as cultural norms, coping abilities and life events that may interact with physical problems. The scientific tradition sees health in terms of physical and chemical processes that occur in the human body. Since most doctors are trained in this way, this science based health care system rejects the metaphysical and oftentimes ignores holistic approaches to medicine.



- c) Understand the concept of cultural filters (or shared cultural experiences, perceptions and beliefs) as they apply to medical/pharmaceutical care in culturally diverse populations.
- d) Demonstrate willingness to apply the principles of cultural competence
- e) Articulate the role of reflection and self-assessment of cultural humility in ongoing professional growth.
- f) Appreciate how cultural competence contributes to the practice of medicine and public health.
- g) Appreciate that becoming culturally competent involves lifelong learning
- h) Demonstrate willingness to explore cultural elements and aspects that influence decision making by patients, self, and colleagues.
- i) Demonstrate willingness to collaborate to overcome linguistic and literacy challenges in the clinical and community encounter.
- j) Appreciate the influence of institutional culture on learning content, style, and opportunities of professional training programs. (Report of an Expert Panel 2013).

Nevertheless, teaching students about intercultural communicative competence in health care is not easy because they are always more focused on pre-clinical and clinical subjects in particular. It takes a lot of patience, training and practice both in and outside the classroom. Still and all, the outcomes are benevolent and rewarding because effective communication between a health care provider and a patient who are both culturally different is a central clinical function and objective and it is one of the first steps in building a successful rapport that leads to a proper diagnosis and treatment. Apart from theory, the instructor should also provide a lot of examples so that the students can practice real life situations. What follows are two examples that can be used in class to practice intercultural communicative competence with students:

Example 1. During the medical interview practice, the students of medicine are drilled to conduct the interview with a patient coming from a different culture. Prior to this exercise, the teacher should explain the basic steps of the medical interview as well as possible cultural barriers that can hinder the interview and consequently jeopardize treatment process such as lack of knowledge about the patient's background and beliefs, patient fear and distrust of caregivers coming from a different culture, racism, bias and ethnocentrism on the part of both caregivers and recipients, mutual stereotyping, ritualistic behavior, differences in perceptions and expectations and language differences. The instructor should particularly direct the students' attention to the role of medical English, which can also hinder health care communication. Albeit it is obvious that language differences can complicate medical interactions, the use of medical jargon can also complicate and impede health care instructions. For instance, the use of words like *rhinitis* rather than hay fever, *anosmia* instead of loss of smell and *dementia* rather than memory loss can be confusing not only to native speakers of English, but to speakers of many other languages (Samovar and Porter; Cooper *et al.*; Gwyn; Klopf and McCroskey; Andrews and Boyle).

The instructor then writes down possible interview questions and points to intercultural verbal and nonverbal communication techniques that should be monitored during the interview (Bakić-Mirić and Bakić; *apud* Bakić-Mirić *et al.*, 260-264):

- *Good morning Ms. X. My name is Dr. Y, hormone specialist* (Every interview should begin formally because in many cultures, there is a greater social distance between caregiver and patient. This means addressing the patient by his/her last name and maintaining this formal relationship until the patient signals that a different approach is appropriate).

- *Tell me Ms. X, what is your present occupation? ... How long have you been working there? ...What precisely are your duties?* (Allow patients to be open and honest because in most cases the patients refrain from telling caregivers that they are visiting a folk healer or taking herbal medication together with prescription drugs).

- *Ms. X, could you please tell me exactly what sort of problems have you been experiencing?* (Once the doctor has established rapport with the patient he/she can ask the patient to explain their reason for coming by letting the patient tell the story in their own words).

- *What do you call the illness? What do you think has caused the illness? Why do you believe the illness started when it did? How severe is the illness? What kind of treatment do you think is necessary? What are*



the most important results you hope to receive from this treatment? What are the main problems the illness has caused you? What do you fear most about the illness? Are you visiting a shaman or a holistic healer? (Never underestimate the possible effects of supernatural tradition or beliefs in the supernatural on the patient's health because if patients believe that their illness was caused by bewitchment, the evil eye or God's punishment they will not take responsibility for their cure).

- *What treatments, if any, are you receiving and are you using folk medicines? What obstacles/factors would prevent you from being able to comply with the proposed treatment plan hereby?* (Indirect questions about the use of nontraditional remedies are always more appropriate and may help the health care provider to arrive at a mutually acceptable course of treatment).

- *Ms. X, I believe that at one point we will have to take a turn, which means that you should start using antibiotics instead of the holistic medication you have been taking. We have to make sure that the bacteria, that is causing of your illness is completely destroyed. This is the only way to avoid further deterioration of your health condition.* (Do not try to impose change or demand compliance from patients because a good caregiver should also be a good negotiator. This means that the patient should be convinced about the instructions he/she must follow on less critical health issues).

- *I am really worried about this gland. It is completely natural for you to have concern, and if you let me, I would like to ask you some questions to be sure what is going on.* When the patient actually reveals such information, the doctor should take a moment to investigate the information i.e., *You mentioned you feel overwhelmed. Can you tell me more about that? You seem quite nervous. Can you tell me why you might be a bit anxious?* (Empathy is crucial because in most cases patients visit healthcare providers at a very vulnerable time in their lives and a caregiver should also show vulnerability, offer compassion and determine patients' views and beliefs. Ergo, a health care provider must put aside beliefs and values of scientific tradition, and, especially, refrain from projecting them onto the patient because the medical problem or issue is not about a caregiver but about the patient and his/her belief system that the doctor needs to understand. So, the caregiver should avoid judgmental language or nonverbal behaviors that the patient may interpret as disapproving (for example making faces, frowning, nodding as a sign of disapproving).

- *It sounds like cutting back on fast food has been difficult for you, but I am glad to hear you have not given up trying. Have you tried organic food?* (Encouragement is another key point for strengthening the patient-doctor communication. The doctor should always reinforce the patient's positive behaviors by offering praise (not patronizing remarks) for the steps he/she has taken up to that point).

- *I feel a lump under your armpit. What we need to do, in order to be sure that it is harmless, is run some tests and wait for the lab results. After we see the results, we will determine the diagnosis and set up the appropriate type of treatment, if needed. Meanwhile, you can go home and continue with your daily activities* (A health care professional must be careful in announcing bad news and determine how much patients are able to take when their diagnosis is concerned because the patient does not need to know everything).

After this, the language instructor should also single out the 6 verbal and nonverbal techniques that will help students understand that both of the aforementioned are equally important in communication, especially when communicating with the patient coming from a different culture (Samovar and Porter; Cooper *et al.*; Klopff and McCroskey; Andrews and Boyle):

1. If the patient does not look you in the eyes when speaking, do not look the patient in the eyes but direct your gaze to whatever the patient is looking.
2. Speak in the same manner as the patient, which means if he/she speaks slowly and softly, speak the same way.
3. Mirror the patient's handshake and apply the same pressure, rather than firmly squeezing his/her hand.
4. If a patient allows a family member to answer questions, refer to the family member and permit him/her to answer the questions.
5. Observe the patient's physical comfort zone for interpersonal communication. This means that if the patient moves close to you in conversation, do not back away and move out of his/her comfort zone (proxemics is very important in some cultures).
6. Make use of the LEARN model that lists a series of things to do while interacting with the patient from a different culture (Berlin and Fowkes):



- Listen with sympathy and understanding to the patient's perception of the problem.
- Explain your perceptions of the problem.
- Acknowledge and discuss differences and similarities.
- Recommend treatment.
- Negotiate agreement.⁵

Example 2. A critical incident in the OTC area specially designed for students of pharmacy. This is the point where students practice their understanding of verbal and nonverbal cues.

Critical incident

Scenario: Ms. Chung is obviously distressed. She has just learned that she has skin cancer.

→ The pharmacist steps from behind the counter and motions Ms. Chung to a more private area. Ms. Chung indicates that the doctor was confusing when she talked about the possible side effects of the medication. The pharmacist goes over the possible side effects and explains what she should do if they occur.

→ The pharmacist observes that Ms. Chung looks confused. So, he stops and asks her if she understands. She says she does. Even though she replies that she understands, he provides a more thorough, detailed explanation. After this explanation, Ms. Chung's facial expressions reveal that she understands.

→ At one point during the conversation, the pharmacist placed his hand on Ms. Chung's hand, looked into her eyes and said in a definitive tone, *I want to help you through this.*

→ The pharmacist makes sure that his body movements and facial expressions are congruent with his words. That is, when he says he is concerned he looks concerned.

→ During the conversation, the pharmacist varies his tone, rate and volume. For example, the pharmacist noticed that Ms. Chung tended to whisper the word cancer. Therefore, he also lowered his voice whenever he used the word. The pharmacist used a soft, calm and even tone throughout the conversation as a means of comfort (Bakić-Mirić, 141).

When the incident is acted out, the following questions are inferred: *Was the approach of the pharmacist proper? Was the approach too personal? How did the pharmacist explain to Ms. Chung how to conduct the therapy? Did the pharmacist observe nonverbal signs? What were they? Was the placement of his hand on Ms. Chung's hand appropriate? How much emotion was involved? Did he/she overdo with nonverbal expressions? Were his/her nonverbal expressions congruent with his verbal ones? What about his voice patterns? What intercultural lore has the pharmacist overlooked?* In turn, the whole class discusses and compares observations from cross-cultural point of view (Bakić-Mirić, 258).

Lastly, the students should, by now, realize that the knowledge of intercultural communicative competence has the potential to improve communication between the health care provider and the patient, increase patient satisfaction with the provider during the encounter, increase patient cooperation with drug therapy plans, improve the quality of care and enhance patient health.

In the 21st century, our multicultural world not only gives way to multiple opportunities but also brings myriad of challenges. The cultural challenges are, in most part, of crucial importance for the health care providers as they often collect sensitive personal and private information about patients, which is in most cases, subjected to culture specific behavior and rules of disclosure. Moreover, living in a multicultural world requires knowledge of different sets of skills for health care professionals, which are needed to competently and effectively maneuver intercultural interactions with patients. Accordingly, effective communication competence plays a significant role in preparing the health care professional to be an effective communicator in intercultural medical encounters because communicating health and illness across cultures is not an easy task. Unless a health care provider becomes fully aware of cultural, and oftentimes, language barriers, the treatment and cure of the patient may be seriously hindered. In simple words, an understanding of different cultural health belief systems, communication styles and individual beliefs will support health care providers to become more attuned to the culturally based health expectations held by people whose cultural background is different from their own. Nonetheless, it is noteworthy to observe that people in all cultures go about their daily lives enacting health practices and values that are deeply rooted in their culture. Knowing

⁵As a point of note, the readers should keep in mind that these strategies are by no means definitive, but should prove effective in the majority of communication situations in any culture.



how to approach a patient from a different culture will only help a health care provider to realize and understand how good they are acquainted with intercultural communicative competence and knowledge about other cultures once they cross international borders. At the end of the day, effective communication between doctor and patient coming from different cultures is a main clinical objective and one of the first steps in building a successful intercultural rapport and effective treatment respectively. Becoming interculturally competent in healthcare communication means not only to develop skills, attitudes and awareness of different cultural values and expand knowledge of particular culture or country but also become aware of how important it is to celebrate diversity by overcoming prejudices and stereotypes about other nations and their cultures.

Thus, introducing the concept of intercultural communicative competence in European medical schools should aim to allow the students to see, understand and learn the very foundations of cultural competence: curiosity and openness, empathy, readiness to suspend disbeliefs about other cultures and beliefs about one's own. This means not taking one's own values, beliefs and behaviors for granted, avoid assuming that they are the only possible and naturally correct ones and the ability to see how they might look from an outsider's perspective who has different set of values, beliefs and behaviors. Finally, the aim of teaching intercultural communicative competence is to promote out-of-the-box thinking, cultural diversity, respect for human dignity and equality of all men by staying in touch with the world and, above all, communicating wisely with it.

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