Promoting Cultural Diversity: Strategies to Develop the Communication Skills of the Doctors Who Perform Their Professional Activity Outside the Romanian Cultural Context[1]

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The role of culture in heath communication started to receive increasing attention in the 1980s with the emerging understanding that health communication efforts needed to respond systematically to the shifting cultural landscape in order to be effective. This created the climate for multicultural health communication efforts. The emphasis on multicultural population emphasized the necessity to incorporate an understanding of culture in international health communication efforts. In 1995, C. Airhihenbuwa noted: "It has become common practice in the field of public health and in the social and behavioral sciences to pay lip service to the importance of culture in the study and understanding of health behaviors, but culture has yet to be inscribed at the root of health promotion and disease prevention programs, at least in the manner that legitimates its centrality in public health praxis" (Airhihenbuwa 1995: 12). In the decade following this observation, health communication theorizing and practice has taken a turn towards incorporating culture in health communication. Therefore scholars have increasingly stressed upon the necessity to develop communication frameworks grounded in the culture and context of those who are at the heart of health promotion efforts. The above mentioned specialist in health communication, Airhihenbuwa, writes that health is a cultural construct and health theory and practice must be rooted in cultural codes and meanings, inherently tied to values. These values make up the transient framework of a person's everyday living. Embedded in and influenced by these values are notions of community rules, traditions, health beliefs, socio-economic ability, societal power structures, education, religion, spirituality, gender roles and exposure (Airhihenbuwa 1995: 12). C. Helman adds that in every human society beliefs and practices related to health are a central feature of culture: "both the presentation of illness, and others' response to it, are largely determined by socio-

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cultural factors" (Helman 1986: 71). This growing awareness of cultural differences globally is based on the understanding that there are many different ways of perceiving and interpreting health across different cultural groups, and, in order to become effective, health communicators need to become aware of these cultural differences (Hammerschlag 1988: 146). Cultural differences were conceptualized as barriers to effective health communication efforts.

Diversity exists anywhere there is not homogeneity or sameness, although "differentness" may have several meanings. Diversity is often viewed as an assortment of contrast and variations. Regardless of one's opinion of diversity, however, it is generally acknowledged that, with differences that may go back to age, culture, health status and condition, ethnicity, experience, gender, and sexual orientation, the variability and combinations are limitless. Concern about diversity is not new. Reflecting society at large, health sciences, despite development of an awesome technology and overwhelming bank of knowledge, have invested relatively little in examining how we might better get along with each other. Few books and journals in the average medical library pertain to facilitating relationships and providing health care in ways that acknowledge diversity.

During our EFL seminars at the "Gr. T. Popa" University of Medicine and Pharmacy, we noticed that virtually every student whom we encountered during classes and discussions admitted incidents of social unease that they attributed to diversity. They were also aware of the fact that nowadays doctors travel a lot and, furthermore, within a few yeas, by the time they graduate, they might think about this possibility of seeking for a job outside the Romanian cultural context. We also realized that few students felt confident that they had adequate knowledge and skills for intervention in those complex interactive situations. The students were, in other words, more aware and sensitive that knowledgeable and skillful, though, probably, for the majority of them, language skills were not a problem. Their lack of confidence was displayed in their communication patterns, which tended to change when topics that they considered "sensitive" arose. Students were sensitive, but few were prepared for situations that involved diversity. Most had learned to tolerate diversity, but not how to live with it in a manner that let them appreciate and value it. They did not know how to effectively manage themselves in a diverse environment. Due to the fact that the number of Romanian doctors that try to find a job in the medical field abroad increases every year, one of the purposes during the ESP seminars (English for Specific Purposes, in our case, Medical English) should be that of preparing our students to confront the great amount of differences they are likely to experience in the doctor-patient encounter that would take place in an English-speaking environment. However this is not an easy goal to meet. We try to present a framework for understanding social processes underlying the significance that is attached to differences, and a set of strategies for communication and intervention to bridge the gasps formed by those differences. The promotion of diversity moves beyond tolerance, generosity and "good deeds", and even beyond common decency, to confronting differences and developing awareness, sensitivity, knowledge and skills that encourage authentic, effective interaction, that is, interaction that is enhanced rather than hindered by differences.

Social Interaction and Communication

Society may seem chaotic at times but it functions through ongoing, patterned interactions. It is in large part through communication and interaction with those around us that we become who we are, learn the patterns and approaches we use to interpret and deal with the world around us, and arrive at conclusions about the relative worth of others and ourselves. The communication of outcomes of the decision-making process is through language, both verbal and non verbal. When those processes involve more than one cultural or subcultural system, they can be readily confused or misunderstood. In health care it is common for interaction to involve making decisions across cultures, or at least to influence such decisions. At times decisions are imposed from one culture to another. To be cross-culturally effective, however, all interaction and decisions need awareness, sensitivity, knowledge and skills.

Cross- or Transcultural Communication

Contact or interaction between persons who identify themselves as distinct from one another in cultural terms comprise cross-cultural communication (Collier 1988: 71). Cultural differences involve patterned lifeways, values, beliefs, ideals, and practices. Cultural and subcultural differences are not limited to extreme contrasts (in, for example, language, national origin, or political orientation), but often involve more subtle differences such as those between religion, class, age or gender groups). According to Y.Y. Kim, culture is conceptualized as applying to all aggregates or categories of people whose "life patterns discernibly influence individual communication behaviors" (Kim 1988: 12−13).

Health Beliefs and Practices

Every society has a culture, and every cultural group has a system of beliefs and practices that reflect its general worldview but also relates specifically to health and illness (Helman 1990: 31). Communication is frequently the first challenge when one considers health care that involves diversity. Recognition of care alternatives, development of confidence in cross-cultural communication skills, and the ability to analyze situations in specific terms, require practice. In order to become comfortable with the skills required for effective interaction in situations involving diversity, practice of those skills is of primary importance. Therefore we do believe that our goal as teachers of ESP (Medical English) is to make our students aware of the necessity to master all these skills and, at the same time, create the necessary background in our seminars and courses to make them familiar with everything that may require the possession of such skills. "Case studies, questions, discussions of myths, simulation, role play and visuals encourage participants to examine their own and others' beliefs and values as a basis for understanding and respecting diversity" (Gorrie 1989: 78).

Awareness, Sensitivity and Knowledge

Awareness and sensitivity are two important elements in an effective cross-cultural communication. Awareness involves recognition of issues that relate to interactive processes. Cues to the presence of issues occur on multiple levels, with many being subtle or covert. Sensitivity implies understanding the implications and meanings of the processes from the points of view of those directly affected. Cultural sensitivity involves learning new information (Pedersen 1988: 17), so that various perspectives can be understood and appreciated. Whereas sensitivity and awareness allow empathy, knowledge promotes understanding. Knowledge of social process is essential to understanding intercultural issues. Most of us have experienced situations in which we were aware and sensitive to differences but lacked specific knowledge and framework that would help to understand the experience. However, awareness, sensitivity and knowledge are not sufficient for successful cross-cultural intervention. Transcultural or cross-cultural skills are also necessary. Cross-cultural communication skills build upon awareness, sensitivity and knowledge to allow effective intervention (Pedersen 1988: 17).

There are four cross-cultural communication skill areas according to Pedersen. The first is the ability to articulate and present an issue or problem as it is perceived from another's perspective. The utility of this skill is obvious as health care providers are frequently in positions to help patients communicate to others who might misinterpret, misunderstand, or impose their own perspective on the patient. The point is, under the circumstances, to decrease the risk of imposition of values and norms that are not those of the client. The second and third skill areas involve recognizing and reducing resistance and defensiveness. The fourth cross-cultural communication skill area involves acknowledgment that we all make interactive mistake and that taking the risk of making an error is preferable to playing it safe and not communicating.

Cultural and Social Diversity

The communication skills needed for exploring multicultural issues are a special case of the core skills used to understand the patient's perspective (both in gathering information and in explanation and planning) and build the relationship. Multicultural interviews were viewed as an extreme example of all medical encounters and the lessons learned were later applied to doctors and patients working within a single culture. In the present day world, one of continuous fluctuation and of people's migration, our doctors have to become aware of the fact that we are reversing the process and exploring how the core skills of discovering the patient's perspective apply to the specific difficulties of multicultural situations where the doctor and the patient often hold differing perspectives. T.M. Johnson says that "each culture is a textured pattern of beliefs and practices, some of which are coherent and consistent and others contested and contradictory" (Johnson 1995: 95). Johnson suggests that doctors must explore a patient's health beliefs and views of their symptoms and illness in every medical interview. If doctors ignore this advice, they risk making assumptions or value judgments or stereotyping patients. This can lead not only to conflict, but also to inaccuracy. In multicultural contexts –

indeed in all cases of diversity between physician and patient – discrimination is a potential problem. Johnson makes the following points which doctors may find useful when consulting with a patient who comes from a culture different from his / her own. A person's culture provides him or her with ideas about heath and illness, notions about casualty, beliefs about who controls healthcare decisions and notions about how steps in seeking healthcare are made. Johnson and colleagues have also developed a useful explanatory model which sets out common differences between Western-trained physicians and traditional ethnic patients. This approach is supported by a cross-cultural study by V. Cugh and others in 1993. Their main finding was that there were a number of barriers to patient satisfaction, to doctors giving a diagnosis and treatment and the patients receiving it. These barriers were related to the patient's cultural experiences, ideas, beliefs, and expectations as well as language difficulties.

P.R. Myerscough (1992) and Z. Eleftheriadou (1996) have also provided useful information about a number of problems related to culture that are commonly encountered by Western physicians. Examples given include the importance of the family structure and lifestyle, women's role, attitudes towards women and their children, dress, religion, food and fasting, and life and death. W.J. Ferguson and L.M. Candib (2002), in their review of culture, language and doctor-patient relationship, found consistent evidence that ethnic minority patients with insufficient English were less likely to engender emphatic responses from their physicians, were more likely to receive less information generally, and were unlikely to be encouraged to develop partnership in decision making. Here is a list of potential points of difference or barriers to effective interaction that require special attention when the cultural and social backgrounds of the physician and the patient are different. In terms of language, the physician must communicate in a language in which he / she is not fluent, he / she is exposed and has to understand the patient's use of slang, accent or dialect etc. In terms of non verbal communication there are some other problems that may come along and function as barriers in establishing a coherent dialogue between the doctor and the patient: physical touch, body language, proximity (closeness / distance), eye contact. In the category of sensitive issues, probable mention should be made of the following: sexuality – including sexual orientation, sexual practices and birth control, uneasiness about some physical examinations, use and abuse of alcohol and other substances, domestic violence and abuse and sharing bad news. But, since we speak about performing a doctor's job in a different cultural environment, the most important category is, nonetheless, that in which we include the cultural beliefs. Here mention should be made of the interpretation of symptoms (what is considered normal and abnormal), beliefs about efficacy of treatment alternatives, attitudes towards illness and disease, use of complementary or alternative sources of healthcare, gender and age expectations about roles and relationships and the role of the doctor and the social interactions related to power and ways of showing respect. Last but not least, there is another category that may function as a barrier as well in establishing the coherent dialog between the doctor and the patient. This is the category of medical practice issues / barriers in which we may include the extent of doctor-patient partnership, the extent of family involvement, meaning personal and family responsibility for

healthcare and treatment, doctor's assumptions, stereotyping or prejudices and the concurrent consulting with a practitioner of complementary or alternative medicine.

Such knowledge of different ethnic or cultural contexts in which a physician practises is useful and, in some cases, vital. It can give the doctor confidence and may allow some "short cuts" to be made. However, the core skills of understanding each individual patient and their particular health beliefs, no matter the culture they may come from, remain essential. Labelling the patient with the attitudes and outlook of a whole race or culture may be just as damaging as not being sensitive to cultural issues at all. The doctor's objective must be to find out each individual patient's unique perspective and experience of illness. This is equally important when both doctor and patient share the same culture. There are therefore two conflicting communication issues to be faced by the clinician, namely how to avoid making assumptions about a patient based on their ethnicity, and how at the same time to value and be willing to explore and understand cultural differences that might make a considerable difference to how you care for the patient. It is not surprising that the development of mutual understanding and trust between a patient and a doctor from different cultural backgrounds often takes time and effort on the part of both parties.

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Abstract

Nowadays with the increasing number of Romanian doctors who are trying to find a workplace abroad, the ability to communicate in a foreign language becomes of major importance. Once these doctors find themselves in the foreign medical system, they are confronted both with the linguistic and cultural barriers. A medical doctor needs to be able to fully understand and communicate with his / her patient. Therefore the aim of our research is to emphasize the importance of discussing with the medical students, during the ESP seminars and courses, the importance of acquiring the necessary communication skills in order to develop the language and interpersonal skills essential to the establishment and maintenance of a good rapport between the doctor and his /her patient. All these would enable the future medical practitioners to carry out their duties in a foreign language more effectively and with greater confidence, drawing the students' attention on the cultural issues and on the different aspects of culture that could possibly cause misunderstanding during the medical encounter.