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DEVELOPING INTERCULTURAL COMMUNICATION COMPETENCE IN FOREIGN STUDENTS ATTENDING MEDICAL SCHOOLS IN ROMANIA

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Abstract: Ever since its publication, in 2001, the CEFR has been the main guide for structuring and shaping the evaluation and teaching process in foreign languages. Although they propose a truly revolutionary communicative approach, the CEFR and the current didactic methodologies acknowledge the cultural background of the newly acquired language only to a limited extent, whereas intercultural communication competence (IC) has been strongly emphasized by the European language policies in recent years, in a world increasingly built on multicultural communities. Foreign students attending the Romanian Medical Universities study Romanian as a foreign language for two main reasons: to adapt to the community within which they will live for at least six years and to be able to interact with patients during the clinical years. Thus, the role of the Romanian teacher cannot be limited to the development of communicative skills, but should also include the effort to overcome superficial representations of the Romanian environment, which is essential to gaining the empathy towards the adoptive society and towards patients. Once this intercultural perspective has been assumed, linguistic competences will develop more quickly and more thoroughly. It is the purpose of this article to identify the appropriate pedagogical approaches able to stimulate intercultural communication, including the exit of foreign students from their safe group, the empathy towards the environment and learning Romanian language through its interactional and cultural sides.

Keywords: intercultural communication, medical language, identity representations, communication activities, language policies.

1. Introduction

More than half of the 20.000 foreign students in Romania[1] attend classes at medical schools from the main cities. Usually, throughout the first three years of study, which are the pre-clinical ones, Romanian is included in the curriculum, so that upon entering hospitals students would be capable of carrying out a dialogue with Romanian patients. Starting with 3rd year semiology, the patient's anamnesis requires students not only to have linguistic competences in the new language, but to also have an intercultural competence (IC), of understanding and respecting the socio-cultural background of the patient. Concretely, this background is built from elements that help us understand the world, and invest it with meaning: values, manner of thinking, language, beliefs, manners of interacting with each other, customs and traditions.

[1] http://www.rfi.ro/social-85336-numarul-studentilor-straini-romania-s-dublat-zece-ani-interviu-audio; http://www.zf.ro/profesii/educatia-la-export-peste-20-000-de-studenti-straini-invata-in-facultatile-romanesti-14978309

IC is important for at least three purposes: to decipher language nuances, to establish the authenticity of the dialogue that constructs anamnesis and, last but not least, to gain the patient's trust. When medical personnel does not have or ignores the IC, it can lead "to stereotyping, and, in the worst cases, [to] biased or discriminatory treatment of patients based on race, culture, language proficiency, or social status" (Betancourt, 2003: 560).

The present study proposes a series of teaching activities that are useful in modelling CI, and easy to insert in between exercises that are specific to language competences.

2. Methodology and theoretical frame

Intercultural communication, which has been initiated only half a century ago, first in the diplomatic world through the writings of Hall[2], has known in the 90s a spectacular development, which answered to a world dynamic that had been difficult to imagine centuries before. If theoreticians such as Hoffstede (1991), Bennet (1993) or Brislin-Yoshida (1994) concentrate on intercultural communication in general, Seelye (1997) and Byram (1991, 2002, 2014)[3] terminologically ground the teaching of the intercultural communication within the context of learning foreign languages.

Our theoretical reference points have two sources, as different as they are complementary. The first source is of European origin and situates the IC within present language policies, which are legitimised by Brussels, just as in the case of the *Common European Framework of Reference*. The second source comes from the United States and defines multiculturalism more specifically in the education of medical students who will have to deal with patients from different cultural mediums.

A. The IC in the European linguistic context

Recently, in the context of a world that is increasingly culturally diverse, professor Michael Byram, one of the artisans of the present European language policies, and his collaborators theorise and exemplify several teaching activities that facilitate linguistic and cultural communication (Byram *et alii*, 2014: 37-52). In the list below we present the teaching activities that the authors propose for the initiation and consolidate of the IC, and which can be easily transposed into specialised contexts, including that of learning Romanian by future doctors:

1. Activities emphasising multiple perspectives
2. Role-plays, simulations and drama
3. Theatre, poetry and creative writing
4. Ethnographic tasks
5. Use of films and texts
6. Image making/still images in class
7. Social media and other online tools.

The authors explain the firm intention of the activities to emphasise the consciousness of different perspectives and to simultaneously construct "skills of observation, interpretation and decentring as well as their openness and non-judgmental thinking" (Idem: 39). In the final

[2] E.T. Hall, *The Silent Language* (1959), *The Hidden Dimension* (1966), *Beyond Culture* (1976).

[3]Hofstede, G. H., *Culture's Consequences, International Differences in Work-Related Values*, Beverly Hills, Sage Publications, 1980; Bennett, M. J., ***Towards ethnorelativism: a developmental model of*** *intercultural* ***sensitivity,*** in: Paige, R. M. (ed), *Education for the Intercultural Experience*, Yarmouth, Maine: Intercultural Press, 1993; Brislin, R.W., Yoshida, T., *Intercultural Communication Training: an introduction*, Sage, 1994; Seelye, H. N., *Teaching* ***Culture: Strategies for Intercultural Communication***. Third Edition Chicago: National Textbook Company, 1997; Byram, M. (v. *Bibliografie*).

part of the study we will adapt the majority of these activities to the needs of the foreign students from Romanian medical schools.

B. The IC in the context of American medical studies

At the beginning of the 2000s, the medical education in the United States started being preoccupied with introducing the intercultural competence in the curriculum, as a result of the amplified diversification of the populations, and of the increased number of ethnic minoritarians, who seem to become majoritarians by 2050 (Kripalani & *alii*, 2006: 1116). Soon after, the "Academic Medicine" journal dedicated an entire issue to discussion about reducing cross-cultural communication. The articles and studied that were included formed the theoretical outline for future contents and for the standards of evaluation necessary to establish the intercultural competence and a compulsory discipline in the curriculum of medical schools. A document that synthesises the useful teaching concepts is found on the website of the Association of Medical Colleges[4] and can be consulted by all those interested. Although in the cited documents emphasis falls upon the standards of evaluation, just as in the initiation of any teaching field, in our study we will only make use of the methodological suggestions from the teaching/learning process, since in Romanian medical schools we are dealing with a pioneer project, an experiment included in the learning of a foreign language. As a result, for the moment we will only make use of Betancourt's scheme, with the three Conceptual Approaches to Cross-cultural Education, whose measurable evolution proves the assimilation of the intercultural competence:

1. Attitudes – students explore and reflect upon culture, racism, tagging, sexism etc.
2. Knowledge – the focus is on the teaching of the unifying cultural characteristics of cultural groups.
3. Skills – students build tools for managing cultural specificity, which rather belong to medical anthropology (Betancourt, 2003: 561).

After the identification of the most evident socio-cultural characteristics of Romanians, we propose a set of exercises and activities that are useful in forming and managing the IC which can cope with the cultural challenges that are encountered by foreign medical students in Romanian hospitals.

3. Cultural characteristics of Romanian patients

Although there are objectors to ethnopsychology, the present portrait-studies of national groups have gathered quantitative and qualitative proof of the characteristics that are common to the members of the group, and that substantially differentiate them from other individuals who are from outside the group[5]. In regards to Romanians, the most recent portrait-study belongs to psychologist Daniel David (2005), who has investigated over 50.000 Romanians, in representative samples, and has then applied a transcultural analysis of the comparison with other nations, and with Americans in particular. From this rich volume we will extract the characteristics of Romanians, from what the author calls *the surface psychological profile*, meaning the traits that are presently evident and not the potential that is attainable in a few years. These represent the characteristics with which a foreign student is confronted and for the sake of coherence we must identify teaching solutions for intercultural

[4] https://www.aamc.org/download/54338/data/culturalcomped.pdf
[5]Terracciano, A., Abdel-Khalak, A. M., Adam, N., Adamovova, L., Ahn, C.-k., Ahn, H.-n., et al. (2005). National character does not reflect mean personality trait levels in 49 cultures. Science, 310,96-100; Hunyady, G. (2003). *Stereotypes during the decline and fall of communism*. New York- Routledge; Iacob, L.M. (2003). *Etnopsihologie şi imagologie.* Editura Polirom, Iaşi.

management. Thus, these are the main traits of a Romanian, according to Professor David, presented here in a simplified manner due to clear space limitations:
1. a personality that is usually defensive, centred on negative aspects (e.g. scepticism, misanthropy, pessimism);
2. a behaviour that does not easily comply with norms and rules;
3. major benchmarks: work, family and religiousness;
4. a lack of trust in people, strangers or acquaintances, with the exception of family;
5. the use of power in a feminine paradigm, characterised by discussions and the search for consensus, although sometimes these are burdened by disputes/misunderstandings;
6. low scores in regards to values such as universalism, benevolence, hedonism, searching for novelties and self-determination;
7. the dissimulation of the importance of Western values with the purpose of creating a good impression;
8. defiance, doubt and relativism are lower, while conformity is high, which makes them predisposed to being submissive to dogmas (in this case religious one) (David, 2015: passim)

Without having the scientific width and rigour of the treaty cited above, a small study, done in 2012 by a human resources company, aims, along the lines of our immediate interest, at the traits of difficult patients and, without being a surprise, it somewhat anticipates the exhaustive portrait discussed above: the refusal of rules, defeatism, preference towards dogmas and alternative explanations, in the disadvantage of science[6].

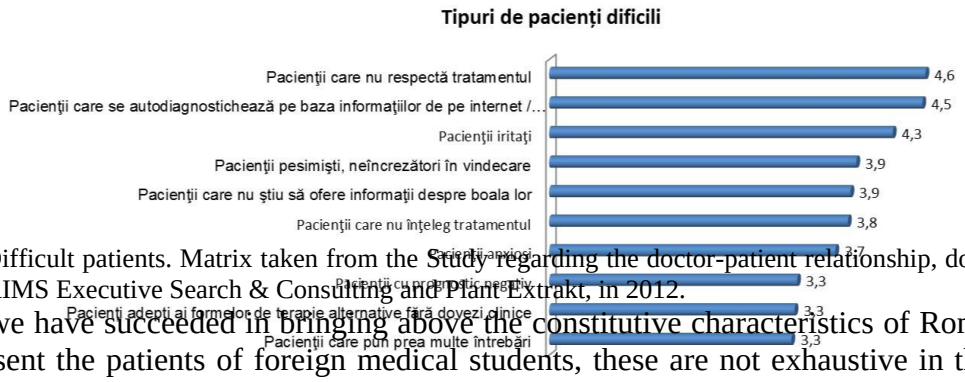

Figure 1[7]: Difficult patients. Matrix taken from the Study regarding the doctor-patient relationship, done by the companies AIMS Executive Search & Consulting and Plant Extrakt, in 2012.

If we have succeeded in bringing above the constitutive characteristics of Romanians, who represent the patients of foreign medical students, these are not exhaustive in the least. These traits are representative from a pedagogical point of view, but a complete ethnic portrait is still in need of numerous nuances.

4. Teaching activities for forming IC with foreign medical students in Romania

Although for the moment in Romanian medical schools there is no special discipline that deals with the intercultural formation of students, the work group is much more homogeneous and easy to manage, both in the process of teaching and that of evaluation, within the Romanian course, for example. Beyond individual variation, there is a psycho-social unity, which has been detailed above, and which allows the establishment of some functional instruments. Unlike the US or Western European states, where the multitude and

[6] http://aims.ro/download/Studiu_Medic_Pacient.pdf
[7] **Types of difficult patients:** Patients who do not respect the treatment; Patients who self-diagnose based on information found on the Internet; Patients who are irritated; Patients who are pessimistic, and sceptical about the healing; Patients who do not know to offer information about their illness; Patients who do not understand the treatment; Patients who are anxious; Patients who have a negative prognosis; Patients who are in favour of alternative therapies without clinical proof; Patients who do not ask a lot of questions.

the difference between minority groups are overwhelming and thus the tendency towards stereotyping is more emphatic, in Romania the process of intercultural education can go more smoothly, from ethnocentrism (denial, defence, minimisation) toward ethnorelativism (acceptance, adaptation, integration) (Bennett, 1993: 22), due to the lack of major variation in cultural challenges during student-patient meetings.

Starting from Betancourt's tripartite approach model – attitudes, knowledge, skills – we will for each describe three demonstrative communicational activities, which are meant to help with forming and developing the IC, and with a coherent means of cultural communication with Romanian patients, respectively.

4.1. The attitudes are the first ones to be visible in professional meetings, but also the most difficult to form and improve. They include humility, empathy, curiosity, respect, sensitivity, and awareness of all outside influences on the patient (Betancourt, 2003: 561). The specific exercises imply especially processes of self-reflection on personal tendencies of stereotyping and efforts to understand the beliefs and behaviour that contradict personal values. It is about questioning cases of tagging, sexism or other types of discrimination.

4.1.1. The identity poster: Students receive Romanian newspapers, scissors and glue. Working in pairs, they create a poster out of a minimum of five clipped images, which has to represent the typical Romanian, as they understand it. The final discussion will give the opportunity for the professor, and perhaps also for colleagues or even for authors, to highlight possible stereotypes that emerge.

4.1.2. The online story platform: From the activities that allow taking in a multiple perspective in the intercultural medium, the most productive one seems to be the construction of narrations (Byram et alii, 2014: 40). Practising controlled productions of fictional messages allow students to step out of their own values, norms and beliefs and live – even if temporary – in someone else's skin. The online Storybird platform (https://storybird.com) allows the use of sets of images and the creation of free online illustrated books. In order to ensure the adherence to the domain, the professor can give thematic titles such as: *My first day in Romania, Everyday conflicts, Why I am different* etc.

4.1.3. *Workshop – The white coat*: is an exercise proposed by Boutin-Foster *et alii* (2008: 108) and consists in a general conversation about clothing semantics. From the meanings of the medical coat, which can suggest a sceptic medium, trust, respect, one gets to the "clothing reading" of individuals from images of potential patients, which are presented by the professor. The aspects that can be subsequently detailed will arise from the commentaries: economic status, education, conformity, sexism etc.

4. 2. Knowledge about a new culture is the easiest to transmit and receive, since it is related to objective facts connected to the newly encountered population: the socio-political and historic context, the economic status of the majority, types of education and usual professions, religious beliefs, the state of the health system, traditional healing practices and, last but not least, the language of the target group, namely Romanian. The exercises are generally those that are specific for language reception competences, meaning for reading and listening.

4.2.1. The game of predictions: A narration that presents a typical cultural aspect is read in stages. Between the fragments, predictions are made regarding what the listeners think will happen. All the ideas are written down, and at the end the predictions that are confirmed by the text are marked. The theme can be a day in Communism, the case of the nun killed through exorcism at Tanacu, a Romanian wedding etc.

4.2.2. The film: One of the valuable films that portray the present doctor-patient relation in Romania is *The Death of Mr. Lăzărescu* (Cristi Puiu, 2005). A typical scene, as is the one from minute 60 to minute 66, is a good opportunity to update and fill the knowledge about the emergency services in Romania. The sequence will be accompanied by a worksheet containing boxes to be filled: the attitude of the coordinating doctor, the attitude of the patient, the relation with the disease.

4.3.3. A lexical exercise: Still in the category of knowledge we also have the language learned for patients. It happens that an inhibiting distance can sometimes exist between the technical language of the doctor and the patient's deciphering capacity. Lexical exercises that associate scientific terms with their colloquial variant can be useful:

1. I gained weight.		a. anorexia
2. I lost weight.		b. dyspnoea
3. I no longer have an appetite for food		c. nausea and vomit
4. I hear noises in my ears.		d. tinnitus
5. I feel I don't have enough air.		e. asthenia
6. I feel sick and I'm vomiting.		f. gaining weight
7. I feel tired.		g. cephalalgy
8. I have a headache.		h. epistaxis
9. I had a nose bleed.		i. losing weight

4. 3. Skills refer to the students' capacity to obtain information from the patient about his/her manner of seeing the disease, the healing, about his/her perception of health and then to their skilfulness in correctly managing this information, once obtained (Betancourt, 2003: 562). In general, when dealing with cross-cultural skills, students are encouraged to ask of patients an explanatory model, meaning a description of the disease from which the manner in which they understand and conceptualize their health problems can emerge. At the same time, the young students learn how to negotiate the treatment in cases when it is difficult to accept and to discuss the decision-making independence of the patient who excessively relates to family, religion or alternative treatments.

4.3.1. Role-playing games: A great majority of patients in hospitals are elderly for two reasons: the more fragile physiological condition and the accelerated aging rate of the population[8]. The role-playing games that can be simultaneously interpreted by two or three groups, with different approaches, are those of a dialogue with pensioners who: - despite diabetes, go on severe fasting;

- refuse to follow a treatment for hypertension according to recommendations, because they have an alternative naturalistic method of treatment;
- do not trust the doctor, because he/she is a foreigner.

4.3.2. Brainstorming: A rapid and productive exercise is that of brainstorming. All the members from the group can propose solutions for negotiating, for instance, with a defensive, cynical patient. All the solutions are written down, and at the end the first most efficient approaches are collectively chosen.

[8] http://www.insse.ro/cms/files/publicatii/pliante%20statistice/Anuarul_demografic-PROMO.pdf, p. 8.

4.3.3. Dramatization: The initiation of a play is proposed, where the main role is that of the patient suffering from asthma, and who is psychologically dependent on the decisions of the family, who is denying his/her illness. The student playing the role will try to solve the problem with the new identity and with the resources that it implies.

Although in the learning process the three approaches are separate from a teaching perspective, in concrete student-patient meetings they are often simultaneous and aim for the same role, that of ensuring an efficient and authentic communication with the patient who come from a different cultural medium.

5. Conclusions

Although it is not entirely new, the intercultural competence is not for the moment a part of the curriculum of European medical schools as a separate discipline, as is the case in the United States. Their standards are a model for context specific nuancing. On the other hand, the European language policies assume and deconstruct interculturality in various activities and recommend it in the process of learning foreign languages. We have combines the methodological suggestions from the two sources and we have proposed diverse exercises, which can make it easy to learn. The process is neither spontaneous nor easy, but once the attitudes, the knowledge and the understanding skills of a new culture are assimilated, the patient's communication and openness are considerably eased. The status of foreign students in Romania is not, as in other cases of intercultural learning, that of the majoritarian who is trying to understand the culture of the minoritarian, but the opposite, that of the foreigner who is inserting him/herself in a culture that is rather fixed, and which s/he manages according to the opportunity of reading it through the lens of intercultural competence.

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