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Challenges in teaching intercultural communication (ICC) for healthcare students

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Including the intercultural aspect in classes can pose great challenges for ESP teachers. First of all, when we try to find the balance between language learning and improving intercultural competence, we may face various problems on how to support both without the two counteracting one another. Furthermore, we must see and acknowledge our competences and responsibilities when teaching communication as ESP teachers. Finally, we have to be knowledgeable in how to gradually improve intercultural communication in learners with different language proficiency levels. In our paper we aim to find answers to these questions based on our experience of teaching intercultural communication to health service manager students.

Keywords: *intercultural communication (ICC), English for healthcare purposes, English as a lingua franca (ELF), health service manager students*

Introduction

Healthcare communication in itself is a highly complex phenomenon, where it is advised to handle patients as individuals and not as representatives of certain cultural groups. Their own ideas, concerns and expectations must be taken into consideration, so that they can feel safe and secure and quality care could be provided to them (Pilling, 2011; Van de Poel et al., 2013; van Servellen, 2008; Wright et al., 2013). Intercultural communication (ICC) in health care adds mainly one more challenge for both the providers and the patients, that is, their use of a shared language – if there is such – must be effective in order to minimise any misunderstandings and to express ideas in a way that is considered appropriate for both parties and in a way that does not affect their attitudes negatively. As such, ICC is thus challenging not only for healthcare providers, but also for the ESP teacher who is to equip these people with the capability of using English as a mediating language in ICC autonomously (Illés, 2012, 2019) and effectively.

This paper builds on our own experience gathered in a setting when we were to teach ICC to two groups of health service manager students for the first time. We launched an intensive course to health service manager

students, and this new experience has made us face various challenges and raise several questions on how such a course should be designed and implemented in terms of smoothly integrating the aspect of improving intercultural competence into language learning. In the following sections our approach to addressing these issues is presented, with a special focus on the challenges of teaching ICC and on the solutions that can be found in order to enhance the effectiveness of the classes.

Background

The ICC course was organised for third-year health service manager students. The reason for the integration of this course into their curriculum was to prepare them for intercultural interactions in their jobs. Health service managers are responsible for keeping contact with patients of all sorts, many times coming from foreign countries, from various linguacultural backgrounds. Accordingly, effective communication is crucial for them, especially if we take into consideration that they basically cannot afford losing clients of their workplaces, e.g., a private clinic or a wellness centre. At the same time, they usually find themselves in situations where business and health care are competing against each other, which can raise several ethical issues. Therefore, it is not enough for them to speak a good level of English, but they also have to use their language resources effectively with any client.

One of the challenges was that in the faculty's BSc programme we have students with various language proficiency levels, so first we had to adjust the tasks to the students' levels of English. Furthermore, many students are already working in positions where they meet foreign patients in their everyday practice, so they already have certain attitudes and strategies in intercultural communication, which we had to take into consideration when planning course materials.

Nevertheless, the timeframe for the classes is highly limited, that is, only two sessions with 4-4 classes, as these students study in part-time training programmes. We were the teachers of the groups. We are fundamentally ESP teachers, with nearly a decade of experience in teaching English for healthcare students, although both of us have further experience in intercultural communication.

Pedagogical considerations

ICC and English language use in ICC being highly unpredictable, we believe that optimal language learning and improving ICC competence are not

product-oriented but process-oriented (Illés – Akcan, 2017), i.e. learning takes place by using the language as a means of communication (Larsen-Freeman, 2007; Widdowson, 1978), so there should be no idealised and prescribed communicative behaviour to be achieved, but the focus should be on the processes of communicating. Therefore, the aim should not be to imitate certain norms, such as English native-speaker language use or the norms of a foreign culture, but to create temporary, interpersonal norms in the process and flux of communication, in other words, in using English as a lingua franca (Seidlhofer, 2011; Widdowson, 2003, 2007) and accordingly, it is not the distance, difference, or discrepancy that should be emphasised, but rather the solutions that result in effective communication.

Our materials and methods

In order to ensure that the flux, the processes present in ICC are in focus, the activities were created with the aim of developing and improving the mental processes used in communication so that we could enhance health service managers' effectiveness when talking in English to various foreign clients. In ICC the providers and the clients have different linguacultural backgrounds, so routine and convention-based communication techniques may fail to result in an effective exchange of information and in the achievement of the interlocutors' communicative goals.

Accordingly, we designed the tasks in a way that learners develop alternative perspectives in terms of their expectations and agendas in a specific communicative situation. We asked them to reflect on both the patients' and their own perspectives and to identify possible expectations in various situations. For example, they were shown photos of fictitious people with their name, age, and nationality added, and learners had to discuss questions about them, such as who they think they are, how they would behave in a healthcare situation, what their fears are, what makes them happy, and how they speak English. Similarly, before acting out any situation, they were asked to reflect on their own planned behaviours, expectations, goals and fears.

Moreover, learners were made to prepare for various situations by generating and exploiting alternative resources, such as language or their communicative strategies, so that they could have alternatives to select from and adapt while using English. Such an exercise was when they were asked to provide information to three clients about a specific therapy in three different ways based on their expectations on what would be hard or easy for the given client to understand, how they would rephrase certain pieces of the

information, what words they would omit or describe (e.g., certain taboo words), where they would use some visual aids, etc.

These preparatory exercises were followed by the simulation of communicative situations where the student acting out the role of the client/patient was given specific instructions on how to create challenges during the simulation – of which challenges the student playing the health service manager was unaware. Therefore, the learners had to engage in continuous problem-solving and find alternative solutions in the communicative situation, thus gaining hand-on practice in adapting alternative perspectives and exploiting alternative resources in a way that their language use could be appropriate in a certain situation. Furthermore, after the simulations they were to give feedback to one another on the perceived effectiveness of the situation by discussion questions, such as what challenges they had and how they tried to solve them, whether they managed to achieve their goals and felt safe, and what would have made the conversations even more successful.

In sum, our main goals were to gradually make learners' attitudes more flexible by broadening their perspectives and improving their creative language use and coping strategies so that they can adapt to any eventualities (Widdowson, 1983) they may come across in ICC. In the long run, the aim must be for them to achieve a mental functioning that can ensure an automatic yet flexible and effective communicative behaviour, which they can apply as a tool when dealing with clients or patients, so that their conscious mental functioning can be dedicated to their professional tasks. Since the human brain is capable of focusing on one mental process at a time (Kahnemann, 2011), it is paramount that the development of healthcare providers' automatically effective language use occurs in safe settings – i.e. without the risk of harming patients, such as in an ESP classroom.

Challenges

As can be seen, ICC can be envisioned as sailing in unknown, often rough, waters, with no secure answers to anchor to, with no stability, with no immediate assistance around to help us (Aleksandrowicz-Pedich, et al., 2003). Therefore, it can be expected that students and teachers may show some reluctance to launch into it. Leaving behind the familiar land, stepping off the stable ground naturally and understandably awakes a strong resistance to change in all of us, be it active or passive resistance, apathy, or ignorance (Hewitt-Taylor, 2015).

Resistance to change

Probably the most difficult part for teachers is that however keen and committed we are about introducing an interculturally sensitive attitude in care and in the classroom in the firm belief that it is in accordance with desirable medical conduct, students may have different opinions.

In the classroom, active resistance to change could be detected when students openly opposed alternative approaches. Just to give one example of the many, when we were trying to formulate questions to inquire about patients' community identity that can influence their health care, one student refused to participate as she saw no point in asking the patients about this She said: "If there is something a patient really wants, they will demand it even without being asked".

The passive form of resistance was also present when students showed no desire to modify what they habitually perform and with this attitude they sabotaged other people's attempts to do so. This proved to be even trickier to overcome than active resistance in the classroom, as students were often reluctant to openly oppose the ideas of the teacher but found ways to avoid engaging in the process. During the pair-works we regularly encountered that while students completed the given tasks dutifully, they performed them mechanically without real engagement. Even if only one student of the pair was inclined to do this, their partner inevitably fell into the same old patterns of behaviour.

Another significant mode of resistance was apathy, where an idea was not completely rejected but students felt that it was not vital enough to sacrifice their time and energy. This was also a significant issue for us as many of our students, although in principle they agreed that communicating with the patients in a more culturally sensitive way is the acceptable norm, also expressed their uncertainty about whether this will be considered as an everyday priority over other more pressing problems, once they return to their real life work environment.

There were also a couple of students who saw ICC as the latest craze and trusted that it would soon be out of fashion, i.e. they opted for an ignoring strategy. As one of our students promptly articulated her opinion, "These British and American scientists are always coming up with these crazy innovations, we had better not pay attention to them as they just come and go".

Addressing the causes of resistance to change

In order to effectively deal with the students' resistance to change, we need to be aware of its possible causes. This way we can eliminate the obstacles preventing the adoption of alternative perspectives and creative language use both in the classroom and in ICC.

As Hewitt-Taylor (2015) pointed out, "*one reason why people may not engage in a new way of behaving is the loss that they feel, or fear, it will bring"* (Hewitt-Taylor, 2015:121). Adopting a more interculturally sensitive attitude requires the students to consider changing their approach to clients or patients which they have been using or experiencing for a long time. The students come from or are familiar with workplaces that operate relatively swimmingly and are organized and managed with established and accepted routines and procedures. These work habits and formulas are the ones that the students feel confident with and can routinely maintain. Abandoning these and facing the unknown consequences of adapting a more interculturally sensitive approach can instigate *"feelings of insecurity, loss of familiarity and loss of control"* (Hewitt-Taylor, 2015:121). In the classroom students experience this threat to their sense of security not only in relation to their healthcare practice but also to the unfamiliar educational environment where not necessarily established processes are taught but tolerance to risk taking. An effective method to reduce the losses or dread students experience is to highlight the reflective and gradual nature of the process and to facilitate students with the autonomy of determining the speed and extent of the change by always evaluating and reflecting on their exploration of ICC. Furthermore, if needed, an open discussion about our teaching methodology can support the establishment of a safe and sensitive classroom atmosphere, as students are offered motivations for certain activities and teachers' authenticity can also be supported and increased this way.

Adopting ICC at work is also likely to affect students' perceptions of their professional roles and responsibilities. It has an impact on their status, i.e. as they are valued as professionals, and the views they, colleagues and patients have of their expertise and skills. When students were attempting to employ an interculturally sensitive attitude, they sometimes showed reluctance because of the danger of leaving behind their familiar expert roles. Again this aspect of resistance to change is also apparent in the students' puzzlement about how to engage with a teacher who is more a facilitator of risk taking than a culture expert. A classroom solution to this type of loss can be to build ICC practice on students' existing skills and expertise and facilitate students' own reflections on how to achieve this. Encouraging and

developing critical creativity in the classroom enables students to come up with their own personal solutions.

The sense of loss and fear can also originate from the necessity that students have to fit the newly acquired ideas and standards into their personal and community narratives and harmonize them with past values and principles. This can prove to be problematic, as their current healthcare environment may still stick to old patterns of communication and struggle to relate to interculturality. We as teachers can create an environment where this loss can be freely explored and articulated and we can encourage students to establish links between this novel approach and their present and past professional practice. Preparing students to move to a more interculturally sensitive way of working must originate from identifying the aspects students are already proud of in their work. We also need to remind students how important it is to think about their own needs and concerns. We have to allocate time for this in the lessons and create an educational atmosphere where conversations are open, respectful and non-judgmental, so that students can safely present their ideas, values and beliefs.

Readiness to change

It is also vital that teachers acknowledge that any form of resistance can be the first step toward the readiness to change, provided the causes of the resistance are successfully addressed. As Prochaska and DiClemente (1982) explain, individuals and groups go through certain stages in the continuum of accepting a novel way of behaviour. These stages are pre-contemplation, contemplation, determination to change, action, and maintenance of the practice.

In the pre-contemplation stage students are often unaware of the need to change so they have not even started contemplating on it. If the majority of the students are at this stage, a lot of classroom time and energy has to be focused here before the course can progress. We felt that many of our students were at this stage at the beginning of the course but we believed that when we introduce the idea, most students would readily move to the contemplation stage. However, we had to realise that unless we devote more time to the causes of students' resistance, they cannot proceed to the next step of development.

In the contemplation stage students are evaluating the benefits and the drawbacks of adopting ICC. Although we hoped that the majority of our students would quickly leave this stage behind, it had to be taken into consideration that some might return to the pre-contemplation stage as they feel that engagement in the activities requires too much energy and devotion.

Determination to change is the stage that can be realistically aimed for to achieve in the classroom, yet it is easy to fall into assuming that students are willing to engage in this new way of communication already at the beginning of the course, and consider this as a baseline attitude. Nevertheless, if the teachers do not devote time and energy to the previous stages, determination cannot be expected to develop, and accordingly no action will take place in the learners' everyday practice, when they revaluate and change their old practices.

Furthermore, it is still not the end-point of development if learners actually take action. We must find ways to foster the maintenance of their changed attitude and practice, otherwise all the energy and effort put into the preceding phases may be lost. It must also be considered that when students move back from the learning environment to their working communities, they can easily fall back to the same old patterns. Accordingly, the activities in class must also provide students with ideas and resource on how to overcome the resistance arising in their day-to-day work.

Addressing the challenges

Consequently, we can see that in order to get learners to reach the level of determination to change, we have to address the causes of their resistance and make them feel that they are ready to change. In other words, if their expertise in healthcare communication is acknowledged, if they can feel that the classroom is a non-judgemental and safe environment for critical reasoning and gradual risk-taking, and if they can see the benefits of a more open and creative problem-solving in ICC, they will more likely engage in developing alternative perspectives in both their classroom work and their everyday professional interactions.

Having alternative perspectives is in a way a prerequisite to creative language use: as long as they stick to their old patterns, they will not start finding alternative communicative and language solutions when meeting new patients or clients. Moreover, their foreign language anxiety, which is quite common in learners with lower levels of English proficiency, can be more easily reduced if learners are encouraged to use various language solutions.

Furthermore, ICC classes must aim for ensuring that the learners actually put their knowledge into action when engaging in real-life communication situations. Thus, it is of utmost importance that they are aware of mental processes that make them capable of automatically adapting their attitude and language use in any conversation. It is also important that they maintain their readiness to change in the long run – i.e. they keep on fine-tuning their mental processes in order to enhance their effectiveness in ICC. Achieving such goals

is not easy when the time of instruction, the number of ESP classes is highly limited, therefore other opportunities for practice must be provided, such as e-learning materials which keep the learners' consciousness of the importance of alternative perspectives and solutions active.

Conclusion

The challenges that the preparation for ICC pose can be most effectively addressed if ESP teachers encourage students to explore the unknown perspectives of their patients and adapt to their expectations with ease so that they can feel that they can be successful healthcare professionals in any situation with any patient or client regardless of differences in culture and language proficiency. Nevertheless, ESP teachers must also be ready to provide their students with activities that represent the complexity and unpredictability of ICC.

References

Aleksandrowicz-Pedich, L. et al. (2003): The views of teachers of English and French on intercultural communicative competence in language teaching. In Lázár, I. (ed.) (2003): *Incorporating intercultural communicative competence in language teacher education.* Council of Europe Publishing

Hewitt-Taylor, J. (2015): *Developing Person-Centred Practice: A Practical Approach to Quality Healthcare*. Palgrave. DOI: https://doi.org/10.1007/978-1-137-39979-3

Illés, É. – Akcan, S. (2017): Bringing real-life language use into EFL classrooms, *ELT Journal*. 71/ 1. 3–12. DOI: https://doi.org/10.1093/elt/ccw049

Illés, É. (2012): Learner autonomy revisited. *ELT Journal.* 66/4. 505-516. DOI: https://doi.org/10.1093/elt/ccs044

Illés, É. (2019): A proposed theoretical model of adult language learner autonomy. *Journal of Adult Learning, Knowledge and Innovation*. 3/2. 41–48. DOI: https://doi.org/10.1556/2059.03.2019.05

Kahnemann, D. (2011): *Thinking fast and slow*. Penguin Books

Larsen-Freeman, D. (2007): Reflecting on the cognitive-social debate in second language acquisition. *The Modern Language Journal*. 91/focus issue. 773–87. DOI: https://doi.org/10.1111/j.1540-4781.2007.00668.x

Pilling, J. (2011): *Medical communication*. Medicina Könyvkiadó: Budapest

Prochaska, J. O. – DiClemente, C. (1982): Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: theory, research and practice*. 19. 276–288. DOI: https://doi.org/10.1037/h0088437

Seidlhofer, B. (2011): *Understanding English as a lingua franca*. OUP: Oxford. DOI: https://doi.org/10.1002/9781405198431.wbeal0243

Van de Poel, K. et al. (2013): *Communication Skills for Foreign and Mobile Medical Professionals*. Springer. DOI: https://doi.org/10.1007/978-3-642-35112-9

van Servellen, G. (2008): *Communication Skills for the Health Care Professional: Concepts, Practice, and Evidence*. Jones & Bartlett Learning: Missisauga – London

Widdowson, H. G. (1978): *Teaching language as communication*. OUP: Oxford
Widdowson, H. G. (1983): *Learning Purpose and Language Use*. OUP: Oxford
Widdowson, H. G. (2003): *Defining Issues in English Language Teaching*. OUP: Oxford
Widdowson, H. G. (2004): *Text, context, pretext*. Blackwell Publishing: Oxford. DOI: https://doi.org/10.1002/9780470758427
Wright K. B. – Sparks, L. – O'Hair, H. D. (2013): *Health Communication in the 21st Century*. Wiley-Blackwell