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Experiences in teaching written intercultural communication (ICC) to healthcare students

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In an earlier conference paper (Bakó-Marshall, 2020) we explored the challenges of teaching intercultural communication (ICC) for health service manager students. That study focused mainly on oral communication, while in this account we would like to share our experiences in teaching written ICC. After presenting our unique methodology of teaching written ICC, we compared students' attitudes to ICC and their written performance in two contexts: in an in-person classroom setting and a virtual Zoom classroom setting. A qualitative analysis was carried out based on short initial questionnaires on ICC attitudes, students' in-class written compositions, their end-term assignments containing two writing tasks with reflections, as well as our own (the teachers') personal assessment. The findings of this investigation show that instruments to elicit information on students' ICC must be used with caution and heightened awareness in order to obtain reliable results. Furthermore, students' levels of English proficiency largely limit the ways they can realize their ICC in terms of language production, which must be addressed both in learning and assessment environments. Additionally, the challenges of healthcare communication must be in balance with challenges of ICC.

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

Introduction

In line with the methodology used in our oral intercultural communication (ICC) classes, written ICC is developed via English interactions in writing, where challenging language use is presented to students and they have to take on the roles of patients from various linguacultural backgrounds so that they can improve their flexibility and creativity in realising ICC. Thus, the emails they have to reply to include language resembling real-life emails produced by non-native users of English, with all the possible challenges such as mistakes with spelling, grammar, sentence structure, and use of false friends based on the writers' mother tongue, and instances of different world views. Similarly, conversations via instant messaging platforms are simulated with one of the students playing the role of the health service manager, and the other the patient with limited knowledge of English and the Hungarian healthcare system. We believe that making students meet such challenges, that is, adapting their frames of reference, providing information in a flexible way, and dealing with complaints empathically, will prepare them for real-life intercultural (IC) interactions. In this paper, we presented our experiences from two learner groups, from 2020 and 2021, from an in-person classroom and an online (Zoom) classroom environment, respectively.

Firstly, as we have discussed earlier (Bakó-Marshall, 2020), ICC development is only possible in a classroom environment where ambiguity, risk-taking, open expression of feelings and opinions, experimenting, and reflections are made possible and encouraged. When the Covid-19 pandemic made in-person interaction impossible not only between the teacher and the students but also among class members, in addition to dramatically limiting all the meta-communicative means, we had to find a solution to the problem of how we can foster digital ICC and at the same time create a classroom where the digital and real well-being of the student is still the main priority. Our course had already been built on students' interaction, discussion, and collaboration, which turned out to be a blessing, as in Zoom classrooms the complete

privacy of the breakout rooms could create a safe environment for many – in contrast to the in-person, whole-class discussions that are cumbersome, time-consuming, highly intimidating, and uncomfortable for some students. Small group work targeted at finding creative solutions for real-life problems also encourages the formation of an atmosphere where students are not passive recipients of information but active participants in a cooperative community, where respect and acceptance of differences are considered the basic principles.

Secondly, written communication in healthcare management tends to alternate between email correspondence, instant messaging, and social media posts. In the case of emails, usually considerable time is available to evaluate, consider, and respond, while instant messaging and the use of social media requires quicker response time. Accordingly, students were given tasks to explore both types of communication, such as exchanging emails and messages amongst each other while taking on the roles of clients and healthcare professionals, and then having some time to reflect on the procedures together. This technique is especially beneficial because when students have the opportunity of reacting to each other's responses, they are practising prolonged self- and peer-assessment instead of expecting the teacher to evaluate and establish what is desirable and appropriate. A further benefit of the online classes was that while during in-person teaching students naturally keep accompanying the received written messages with meta-communicative and verbal comments, in the online space they were forced to rely on the written texts only.

Background

The use of English in an ICC classroom

Generally, our students consider the subject ICC as part of their language education, mainly because the official and desired language of the course is English. This factor, on the one hand, leads to an artificially created, but still natural, ICC environment, which can enhance the development of certain ICC attitudes, such as tolerance of ambiguity, uncertainty, adaptability, and flexibility (Başöz 2015; Deawaele–Shan Ip, 2013; Ely, 1989). On the other hand, this ambiguity between ICC training and language education causes students to become confused about the learning goals, as students want to improve vocabulary, practise grammar, and most importantly receive clear-cut instruction about desired language usage, which is quite opposite to the aims of ICC classes. In addition, using a second language for communication and reflection evokes great anxiety in students, especially in classes where students have considerably less experience using English. This confusion and the resulting tension are even greater when it comes to written communication and is further increased during the assessment.

Despite the considerable amount of time and effort invested into dispersing and compensating for these undesirable and impedimental concerns associated with the learning environment, their consequences are still detectable in the students' classroom and assessment performances. Students tend to rely on and have recourse to schoolbook formulas and clichés, regardless of our attempts from the very beginning of putting great emphasis and highlighting to them our wish to prepare them for English as a lingua franca (ELF) language use, where "*the connections between language and sociocultural forms, practices and references are likely to be diverse, complex and emergent*" (Baker, 2011:6). Although we continuously emphasise that there is no specific target culture to which their English should conform, they tend to fall back on a traditional perspective of the "proper" usage of the English language, most probably due to their previous language learning experience. Such resistance to change, as we have presented in our last paper (Bakó–Marshall, 2020), is a substantial obstacle to overcome in ICC training. Particularly, this happens to be the case when health management students learn how to

correspond with clients and carry the additional burden of knowing that every word they write is recorded and retrievable and can later be used against them even in legal proceedings.

Assessment of students' development in ICC

Facing these difficulties, we had to find a utilisable model of ICC assessment that would be complex enough to truly investigate our students' development in the field of ICC. The conceptualisation of ICC is a complex theoretical construct with a vast number of different definitions. Many of these definitions are based on the tripartite distinction between cognitive, affective, and behavioural factors while linking IC competence to *“how individuals socially position themselves in interaction (e.g., according to their nationality, gender, age, social status), to their awareness of such positioning, and to their willingness and ability to recognise and negotiate the multiple identities of others as much as their own”* (Borghetti, 2017). Furthermore, we had to tackle the conflict between intercultural competence and performance, so we decided to integrate the additional distinction of internal and external outcomes introduced by Deardorff's Pyramid Model of Intercultural Competence with special emphasis on the models' application in Deardorff's Progress Model of Intercultural Competence (Deardorff, 2006). As it has been pointed out, it is *“possible for an individual to achieve the external outcome of behaving and communicating appropriately and effectively in intercultural situations without fully achieving the internal outcome of a shift in the frame of reference”* (Deardorff, 2006:257), which is clearly observable in our students' behaviour. However, as our findings also suggest, the degree of appropriateness and effectiveness is *“more limited than if the internal outcome had also been achieved”* (Deardorff, 2006:257). Therefore, we have placed special emphasis on developing internal factors of ICC, such as adaptability, empathy, and flexibility.

Healthcare communication in private practice and ICC

The third major aspect that enormously interferes with our students' IC competence and performance is what is referred to by medical ethicists as 'the double agent problem' (Veatch, 1983). This occurs when the professional is simultaneously an agent for a profit-making organisation and an individual client seeking medical care. Health tourism organisers are continuously in the grip of the classical double agent bind when *“loyalty to the corporation may conflict with that which is traditionally owed to the patient”* (Veatch, 1983, p.144). This conflict is further complicated by the different perspectives on reality and ethics, as *“reality is seen primarily in terms of the objectives, external physical world, whilst values and ethics are seen as a separate, subjective and personal attribute”* (Sifile et al., 2018, p.46). While companies often create culturally neutral (a highly controversial concept in itself) moral codes of conduct, individuals still carry within their own culturally embedded ethical and moral values and act accordingly in given circumstances or at least experience significant tension and anxiety when making decisions. When it comes to the attitude and affective components of ICC, the dilemma also inevitably arises as how we can approach, not to mention, improve and even assess areas which belong to students' private feelings and identity-related personal characteristics. As Claudia Borghetti posed the problem, *“while it is unquestionable that some attributes (for example, 'curiosity', 'openness', 'empathy') are catalysts for IC development, one wonders to what extent assessors should feel licensed to express evaluation or even simply their opinions when someone else's identity (and diversity) is at stake”* (Borghetti, 2017).

Methods

Participants and Instruments

As mentioned earlier, in this study we look at two of our written ICC groups, one of which had the course in 2020 in an in-person setting and the other in 2021 in an online (Zoom) class environment. All the students were third-year, part-time, Hungarian health tourism manager students and the lessons took place in the spring semester of their third year, in two 180-minute sessions. All students had the oral ICC course in the autumn semester of the same school year. The teachers of the courses were the authors of this paper. In both years, two groups were created based on the self-reported English proficiency of the students and thus one group was made up of students having an English proficiency below B2 level (B2-), and one with B2 level or higher (B2+). Almost all the students had working experience in health care and a large proportion of them in multicultural healthcare settings.

Our research instruments were integral parts of the course: an initial survey asking students about their attitudes to ICC and the outcome assessment handed in by the students as the final assignment for the course. Both instruments included a checkbox where students could indicate if their answers can be used for our research. Accordingly, all students who expressed they did not want us to use the data provided by them in either of the instruments were excluded from this study and similarly, incomplete surveys or assignments were also excluded. Altogether data from 51 students were included in our investigations: with 20 out of 24 being from the 2020 in-person group and 31 out of the 43 being from the 2021 online group. As for their language proficiency, in 2020, 10 B2- and 10 B2+ students were included, in 2021, 19 B2- and 12 B2+ students were included.

Data collection

Initial survey

The initial survey was given to the students on paper in class in 2020 and sent as an online form to students in 2021. This survey was worded in Hungarian (students' mother tongue) and answers were collected in Hungarian so that the students could express their attitudes to ICC without any limitations their English proficiency may pose. Students' names were also collected for further comparison with their outcome assessment.

The students were given 5-10 minutes at the beginning of the course to answer these three questions in the initial survey – as seen in our translation here:

- What do you find challenging in intercultural communication?
- What do you pay attention to in oral intercultural communication?
- What do you pay attention to in written intercultural communication?

Outcome assessment

The outcome assessment of the course was a final assignment that the students had to send to their teachers electronically within one month after the lessons finished. The outcome assessment was built up of two tasks, each of a written product and a reflection on producing it. The two groups (B2- and B2+) in each year were given two tasks: one that was the same, and one that was different. As in this paper we wished to compare the two groups, the results from the task that was the same in both groups were placed under scrutiny.

The task we analysed in detail was the students' reply to an e-mail in English where a French patient was making a complaint in English after being treated at a Hungarian private healthcare facility (see Appendix 1). The content and language of the e-mail was created by us, building on our French knowledge and experience of interacting in English with French people – e.g., *the doctor me examined*. Furthermore, Google Translate was used to find possible false friends for French users of English or expressions less commonly used in English but existent in French in a form that was somehow different, such as *make attention, doctour, reclamation, misconduct, inconscious*. Furthermore, in this task we also decided to experiment with a situation in which the intercultural aspect was much more subtle, therefore students could not ease into simplistic solutions but needed to mobilise and exhibit their individual and more internalised attitudes and skills. The second part of this task was to provide reflections in Hungarian by answering two questions – as seen in our translation here:

- What did you find challenging when answering this e-mail?
- What did you pay attention to while writing your reply?

Data analysis

All the data from surveys and outcome assessments were uploaded into a qualitative data analysis software (MAXQDA, 2020) for analysis by open, selective, and axial coding. Codes for emerging concepts were added by one of the authors, while selective and axial coding were done together by both authors. The axis of the coding system was built based on Deardorff's model (2006), that is, codes were assigned to the larger code groups – as well as the subgroups – in terms of the individuals' attitudes (respect, openness, tolerance of ambiguity) and knowledge (cultural self-awareness, cultural knowledge, sociolinguistic awareness) and the external (effectiveness and appropriateness) and internal outcomes (adaptability, flexibility, empathy) of the interaction.

Results and Discussion

The first conclusion we could draw from our research was that the instrument we used to explore students' ICC strongly influenced which areas of their attitudes and skills could be assessed. While both instruments could elicit how students tolerated ambiguity in ICC, their pronounced awareness of cultural differences could only be observed in their answers to the initial survey, where they had to answer general questions about ICC. In the outcome assessment task, where the intercultural aspect was more subtly evident, the complaint of a specific patient had to be dealt with, allowing us to more appropriately access the students' openness and readiness to withhold judgement. Accordingly, the data from such different instruments cannot and should not be used for assessing students' development. Furthermore, since these students already attended an ICC course with us a few months prior, they must have had certain knowledge on the topic and preconceptions about what we expected them to write as answers to our questions.

Secondly, also rooting into the nature of the two instruments, it could be seen from the initial survey that although students with lower levels of English proficiency shared various ways on how ICC can pose challenges and how to adapt to these challenges to ensure the effectiveness of the communication (e.g., using simple language that the patient would understand), when faced with the challenges of the e-mail task in the outcome assessment, they barely recognised them and accordingly showed minimal ways of adaptation (Figure 1).

Figure 1. Verbalising challenges and adaptation in ICC

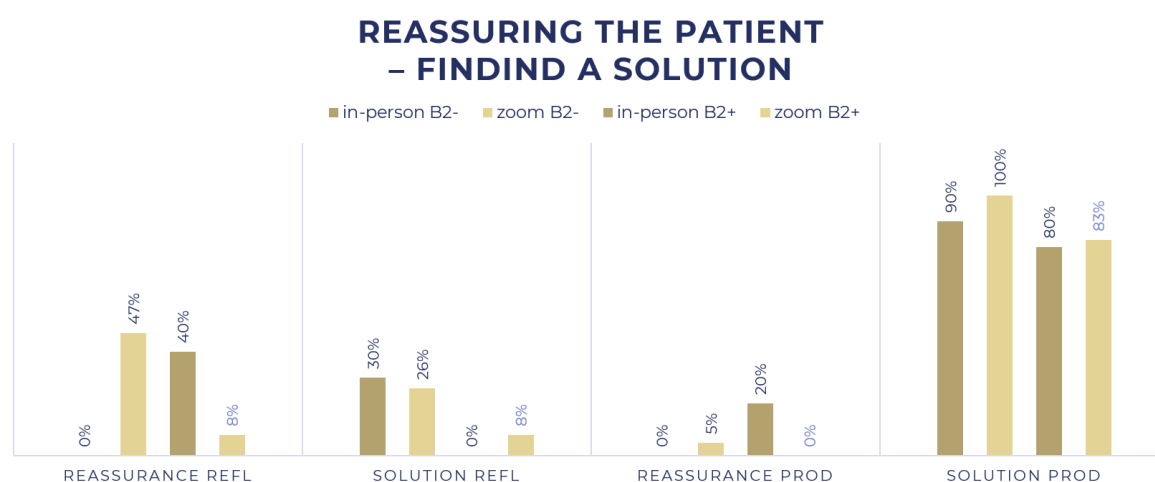
CHALLENGES in %	iniQ SUM	outA SUM	ADAPTATION in %	iniQ SUM	outA SUM
in-person B2-	90	20	in-person B2-	40	30
zoom B2-	84	32	zoom B2-	68	21
in-person B2+	80	90	in-person B2+	70	70
zoom B2+	83	83	zoom B2+	67	83

NOTE: in-person B2-: students with B2- level of English proficiency in the in-person classroom; zoom B2-: students with B2- level of English proficiency in the on-line/Zoom classroom; in-person B2+: students with B2+ level of English proficiency in the in-person classroom; zoom B2+: students with B2+ level of English proficiency in the on-line/Zoom classroom; iniQ: in the initial survey; outA: in the outcome assessment; given in percentage)

As can be observed in Figure 1, students with higher levels of English proficiency were able to tackle the challenges of ICC more consciously, while students with lower proficiencies had problems detecting and addressing these challenges when engaging in written interactions with a patient. Nevertheless, it must be highlighted that although the outcome assessment was capable of revealing students' internal approaches, such as adaptability, flexibility, or empathy, the external outcome of these written ICC interactions cannot be judged properly, as the writer and recipient of these e-mails are fictional characters. This is one of the greatest limitations associated with classroom environments and assessments, but based on Deardorff's model (2006) we can assume that if students have the attitudes and knowledge necessary for effective ICC, as well as show internal outcomes necessary for optimal external outcomes, the chance for them to effectively engage in real-life ICC is higher.

Thirdly, it must be kept in mind that the context for these ICC interactions should be based on the healthcare system. Thus, the effectiveness and appropriateness of the communication were evaluated based on the success of the care provided and to what extent the patients' problem was addressed and resolved. In line with this, it can clearly be seen that the students' primary focus was to reassure the patient and find a solution to the patients' problem (Figure 2).

Figure 2. Reassurance of the patient and finding a solution to the patients' problem as verbalised in students' reflections and included in their written products



NOTE: in-person B2-: students with B2- level of English proficiency in the in-person classroom; zoom B2-: students with B2- level of English proficiency in the on-line/Zoom classroom; in-person B2+: students with B2+ level of English proficiency in the in-person classroom; zoom B2+: students with B2+ level of English proficiency in the on-line/Zoom classroom; refl: in their reflections; prod: in their written product; given in percentage)

Regardless of their English proficiency, almost all students offered a solution to the patient in their replies, even if they did not consciously verbalise it in their reflections. As for reassurance of the patient (e.g., expressing that they empathise and trying to do everything they can to compensate for the negative experience the patient had), it was more pronounced in the reflections task, even though it only remained as a small percentage. One possible explanation for this may be ‘the double agent problem’ (Sifile et al., 2018; Veatch, 1983) that may cause the healthcare provider to develop anxiety and tension, consequently resulting in resistance to change and rigidity in the solutions offered, and thus making them recourse to simpler ways of addressing patients’ problems that tend to be more comfortable for the provider. This dilemma seemed to dominate students’ solutions, forming obstacles with more conscious interactions in ICC.

Conclusion

The greatest challenge for teachers of ICC in a healthcare setting is to help students find a balance between the demands of healthcare settings and intercultural communication. Tasks aimed at improving healthcare students’ ICC attitudes and skills must be created with this in mind, and both healthcare and ICC challenges must be addressed when written production or reflection is required from students. Furthermore, the form of elicitation of ICC attitudes and skills largely influence the answers students provide, and in order to reveal learners’ internal approaches to ICC, goal-oriented tasks must be given, but the negative impact that a lower English proficiency may have on the students’ performance must be considered since their focus tends to shift towards understanding and producing texts in English rather than solving the ICC challenges. As for the comparison of in-person and online education, it can be concluded, based on our highly limited data, that no difference can be observed in the performance of students; yet as our experience shows, the intimate atmosphere of a breakout room in Zoom opens the door to more relaxed and fruitful conversations, which is vital in developing ICC skills.

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Appendix

Appendix 1. The e-mail students needed to reply to in the outcome assessment

Dear Hospital,

I am making a reclamation because I were maltreated in my treatment last month.

When your doctour (Dr Horvat) me examined, he did not make attention to me, he was on the telephone, some people entered the room, while I was non-dressed, they talked with one and the other. It was very humiliante.

After the examination the doctour sat himself and started asking me some questions, but I couldn't sit myself, and I felt the vertigo, and I fell. I was unconscious for minutes, and I hit my head, and I had to rest in your hospital for another 3 days.

Now I received the invoice from your clinic, and I think it is injust that you me charge money for the days I had to rest in your hospital because of your doctour's misconduct.

I want to pay only for what I signed the papers when I went to your hospital.

Waiting for your response,
Mme Matilde Chevalier