

Cross-cultural communication in medicine: questions for educators

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Most research into medical communication has had a western setting. It has been undertaken by western researchers and been influential in shaping communication skills curricula. However we know much less about what communication is effective under other circumstances. This article highlights gaps in our knowledge from research in this field, and poses attendant questions for debate by medical educators. We consider the following key aspects of debate on cross-cultural work. (i) To what extent can our understanding of general principles in other cultures be summarized and presented for teaching in a way which does not descend into caricature? Alternatively, can features of other cultures be presented in ways which do not descend into particularity? (ii) Can such paradigms as 'patient-centredness' be transferred from culture to culture? Should they be presented across cultures as features of 'good' consultations? (iii) What use can be

made of the role of interpreters for teaching purposes? What importance does it have to the educator that a doctor may not be a native speaker of the majority language of the culture in which s/he is operating? (iv) Although the language of illness, and particularly metaphors associated with illness, are studied in other cultures, the way in which illness is metaphorized in British English is seldom discussed. What can educators learn and teach from a study of such matters? (v) What are the implications for communication skills teachers of the need to present materials within a culturally diverse environment?

Keywords *Communication; cross-cultural comparison; education, medical, *methods; faculty; physician-patient relations; *teaching

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Introduction

Our understanding of medical communication across cultures, or beyond the culture of the western, industrialized world, remains slight. There is a considerable cross-cultural research tradition in medical anthropology, particularly on the links between communication, medicalization, the social construction of illness and the disparagement of folk beliefs.¹⁻³ There is also substantial research into language use across cultures, both in general⁴⁻⁶ and with reference to the workplace.⁷ Yet of the huge amount of work that has been undertaken in the last 25 years on medical communication⁸⁻¹⁰ almost nothing has been concerned with cross-cultural issues.¹¹ Perhaps the only thing that we do know is that patients across cultures believe that

'good' communication (however defined) is an important feature of successful doctor-patient encounters.^{12,13} This article highlights some key issues arising from cross-cultural communication research in medicine, and poses associated questions for debate by medical educators.

Culture and point of view

Cross-cultural research presents an acute example of the familiar debate between qualitative and quantitative paradigms. It is the instinct of the qualitative researcher to particularize, to describe in detail what has been observed. It is the instinct of the quantitative researcher to generalize, to reduce what is observed to patterns. Seen from a certain distance, all human beings are identical. Move closer and all seem unique. What point of view is best depends on what one's research purpose is.

The danger in the cross-cultural field is that at one extreme of particularity it is difficult to detect more than the travel writer's vision, while at the other it is all

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Key learning points

Almost all communication skills research in medicine has a western setting, and it is not known whether conclusions based on this research are generalizable.

Research is needed in such key areas as the cross-cultural transferability of such concepts as 'patient-centredness', the language of illness, and the provision of successful opportunities for learning.

Teachers working in culturally diverse societies must be sensitive to the potentially very varied expectations and requirements of patients from different cultures.

too easy to recognize the demon of stereotyping, in which an 'understanding of culture' comes to mean no more than the memorization of a list of behaviours that are different from our cultural norms. This kind of reductionism is self-evidently lazy, and at worst casually racist. Yet for the practical purpose of successfully teaching communication with a patient, it would be perverse to ignore summary patterns. For example, however, an individual Muslim behaves, it is generally true that talking about alcohol abuse to a Muslim will have a different resonance than it will when talking to a non-Muslim. There are cultural schemas¹⁴ which we may use as touchstones to help us interpret the patient's world.

At the other extreme, the careful teasing out of detail makes for a kind of sophistication which is not easily remembered or applied. A famous example is Krause's¹⁵ study of the Punjabi phrase *dil ghirda hai*, or 'sinking heart'. Helman's¹⁶ summary of this concept is itself well-known, but – even as a summary – is at a high level of particularity:

'Sinking heart' is...especially linked to 'a profound fear of social failure', and to cultural values which stress the importance of carrying out social obligations, being able to control one's personal emotions, being altruistic and not too worried and self-absorbed, and – for men – of being able to control the sexuality of their female relatives. Failure in any of these... may result in a loss of *izzat* (honour or respect) in the community, and result in *dil ghirda hai*. Like many folk illnesses therefore the syndrome blends together physical, emotional and social experiences into a single image.

It is hard to see how the concept could be rendered more succinctly than in this discursive manner. It is a

complex summary which nevertheless raises profound questions about how different cultures perceive and metaphorize illness,^{17,18} how they medicalize it and how language cuts the cake of the 'problematic experiences'¹⁹ of human suffering. If teachers could facilitate debate about such concepts without losing their complexity, there is clearly rich potential for learning.

Interpersonal relationships

There is a western presumption that patient-centred medicine – essentially a construct of western research – is 'good'. And, moreover, that it is realized through the kind of surface behaviour which forms the stock-in-trade of the communication skills teacher (ask open questions, negotiate management, and so on). Perhaps the primacy of both the patient-centred paradigm and the interest in surface behaviour need to be challenged if we are to promote more effective communication for other cross-cultural contexts.

Different cultures conduct professional relationships differently. The concept of power, for example, is one area of difference; and the concept of politeness is another. As far as the former is concerned, the distribution of power and the extent to which consultations in different cultures are both patient-centred and successful, may vary widely. There is, for instance, recognition that negotiation with a patient 'should not always lead to acquiescence to Western views of informed consent, truth-telling or patients' autonomy'.²⁰ This recognition then introduces a wider debate about cultural relativism, and how one deals with, for example, conflicting systems of ethics in a cross-cultural consultation. Further research could usefully build upon research traditions which have centred on power^{21–23} and patient-centred medicine.²⁴ Some studies touch on this indirectly, in a sophisticated manner,²⁵ but this is relatively rare.

Given the lack of either description or evaluation of communication across cultures, educators might turn to other sources for guidance. In particular, it is clear that the typical features adduced as evidence of patient-centredness (relatively little doctor talking time, the use of open questions, etc.) are very similar to those which are taken to be evidence of student-centredness in education.^{26,27} These features are also presumed to be prima facie evidence of a more equal distribution of power within the professional context. The political value of this is often taken for granted. However, it is also often claimed that in many contexts (for example, in South-east Asia) students learn extensively with teacher-centred methods. And it is a reasonable

hypothesis that many patients are reassured by ostensible shows of power from a doctor-centred consultation.

Similarly, the way in which appropriate levels of politeness are represented is a probable source of problems. Famously, the British seem abrupt to the Japanese, the Germans seem abrupt to the British, and so on, but the issues here are complex. For example, a common source of irritated misunderstanding to westerners is the manner in which some cultures introduce the true topic of a discussion relatively late in an interaction. This may be accounted for by the notion of 'free goods':²⁸ different cultures, that is, treat different things as being common property, with all participants in an interaction having equal rights to them. For many cultures, time is one of these free goods: there is no sense of 'wasting *someone else's* time'.

These concepts – and there are many more parameters of cultural difference – invite a straightforward range of questions to which we do not have answers, for example:

- Do representatives of some cultures want a more doctor-centred approach than others?
- Do consultations in the UK (or elsewhere in the West) differ significantly when the participants are from different cultures?
- Are consultations themselves culture-specific? (Is there a 'British' consultation? A 'Chinese' consultation?)
- Do doctors from minority ethnic cultures have more than one consulting style, which they routinely use with different cultural groups? Indeed, how is a consultation between those with a shared ethnicity modified by differences in the participants' class and gender?

Interpreters mediating communication

Studies tend to show a demand for interpreters (or bilingual staff),^{29–32} and the advantages they offer are obvious. However a critical question for research is to what extent the presence of an interpreter actually helps understanding of medical encounters in addition to offering reassurance. Understanding requires familiarity with context as well as dictionary definitions of the words used, and the extent to which native speaker patients understand the context of medicine varies considerably: Medicine may not be a foreign language, but for most patients it is 'double Dutch'. A more sophisticated sense of what we mean by 'understanding'³³ would help. This may also emphasize that understanding other cultures, other languages and

other individuals are versions of understanding our own culture, language and self. For educators, encouraging learners to work with interpreters may help them to understand their value. However beyond this are deeper issues, seldom touched on in medical education, about what it means when we claim that a patient 'understands' what we say.

The language of the doctor

Surprisingly, the fact that the doctor may not be a native speaker of the majority language of the culture in which s/he operates is seldom discussed, despite for example the recent drive in the UK to compensate for a shortage in doctors by recruiting from elsewhere. A few studies³⁴ deal directly with the problem while others discuss English-medium medical education, e.g. in the Arabian Gulf, for those who are not native English speakers.³⁵ However we are unaware of work exploring this in any depth. Of 22 doctors referred between June 1998 and February 2000 to one of the present authors (J.R.S.) as having a problem in communication in a region of the UK, 11 have been non-native speakers. This suggests a real problem which is not presently being addressed.

In some cases, the root problem may be an underlying educational deficit which makes it difficult for a doctor to develop intellectually. Sometimes it may be that a doctor is simply relatively new to the host culture, and finds it difficult to interpret. Sometimes the doctor's self-presentation may be misunderstood: German speakers come across as abrupt because that is how German phonology is. Sometimes the straightforward language strategies used by all speakers of a foreign language may have consequences. For example, good language learners routinely let pass unchallenged stretches of language which they do not understand, knowing that context will usually help them to make sense of difficulties retrospectively, and they avoid topics on which they are not confident.^{36–38} The potential for missing important clinical information is obvious.

There are relatively few textbooks on the market for doctors or medical students who need to improve their English. Glendinning & Holmstrom³⁹ is the most easily available. As regards the teaching of reading and writing, particularly to non-native speakers, the tradition of genre analysis⁴⁰ has a healthy track record. There are a number of good texts on study skills for overseas students of all disciplines, though not specifically for medicine. One which has proved very successful is Wallace.⁴¹ Teaching materials for spoken language are hard to come by: *Those things you say...*⁴² provides plenty of authentic language use, and models a high

standard of primary care consultation at least, but though it is centred on the teaching of communication skills, it is not specifically designed for non-native speakers.

The language of illness

There is a research tradition into the way in which non-western cultures use the language of illness, and particularly into how it is rendered into metaphor. Curiously this tradition takes account *only* of these cultures. Pugh⁴³ notes how North Indian culture speaks of 'burning', 'stabbing' and 'gripping' pain. Yet this is self-evidently similar to the unremarked imagery of English. Teachers might ask how they can usefully encourage discussion about the use of metaphor in their learners' cultures as a means of placing cross-cultural similarities and contrasts in context.

Communication skills for doctors

Although some medical training is beginning to prepare doctors to work in a culturally diverse society, there is a long way to go. Learning a range of transferable and generic skills has been suggested. These include responding to an *individual's* culture in its broadest sense, developing a heightened awareness of one's own attitudes to difference, and 'sensitivity' to issues of stereotyping, prejudice and racism.⁴⁴ A grounding in the structural influences upon health and health care, including social power and disadvantage, has also been emphasized.⁴⁴ However we currently lack the evidence and experience to inform training. Although this is beginning to attract debate and some basic teaching resources,⁴⁵ further development and evaluation are needed, including the negotiation of institutional challenges.

Conclusion

For educators, the central point at stake is seeking an appropriate balance between information content, sensitization to cultural diversity as an issue, and teaching which is designed to help students and doctors develop a flexible range of skills. Teachers face a number of questions and challenges in determining how cross-cultural communication should be taught:

- Should information about the expectations of different cultural groups regarding communication with doctors be given as part of the course?
- Is the transfer of culturally specific information (e.g. the dates of Ramadhan) best treated as the main

focus of learning, or as a useful addition whilst concentrating on the acquisition of core skills?

- Should culturally specific information be integrated into the overall communication skills programme?
- Should courses concentrate on sensitization and flexible, generic skills?

As educators seek answers from their experience and evaluation of teaching, they need further evidence. It is now crucial that the field of cross-cultural communication develops to help them, because our understanding of medical communication at present is an understanding of a tiny proportion of doctors and patients around the world. Ultimately, of course, we need to know whether our attempts to improve cross-cultural communication can lead to better consultation and health outcomes.

Contributors

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