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TEACHING INTERCULTURAL COMMUNICATION COMPETENCE IN THE
HEALTHCARE CONTEXT

By

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Bachelor of Arts, The University of Montana, Missoula, Montana, 2006

Professional Paper

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Abstract

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The purpose of this project was to design a training program focused on intercultural communication competence in the health care industry. While international students make an important link between different cultures, serve as great resource in the exchange of cultures and ideas, and make large contributions to the U.S. economy; international students also pose new challenges for higher education. One of the challenges that came up as a result of the diversification of U.S. campuses has to do with intercultural competence, which is an important quality for anyone who wishes to competently and effectively navigate intercultural interactions. Along these lines, it is important to equip college staff with intercultural skills to competently navigate intercultural interactions. Health care service is one of the college service providers, that is used by international students to large extent. Providing intercultural communication competence training to health care providers on U.S. campuses will not only help higher education staff and service providers to competently interact with students and scholars from other cultures, but this will also assist easier integration of international students and scholars into U.S. college life.

Intercultural challenges are especially great in the health care industry, because this setting often requires the sharing of sensitive personal and private information about a patient, which relates to cultural norms of disclosure and behavior. I designed the training on intercultural communication competence for the Curry Health Care Center (CHC), which is the primary health care provider at the University of Montana. Working with CHC on this project will hopefully not only help health providers be able to effectively interact with international students, but will also raise the awareness of how important it has become to be interculturally competent in contemporary workplaces. The integration of intercultural communication competence as a core value in health care industries will not only prepare staff to competently interact with international patients, but will also send a strong message about the organizations' commitment to provide equal access to all patients.

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Introduction

Over the last few, the United States has attracted immigrants from different parts of the world. As a country of immigrants, the United States first attracted immigrants from European countries, but recently there are more immigrants coming from Asia and Latin America (Lucas, 2007). Along with diversification of the population in the U.S., over the last few decades there have been increased efforts to bring more international students to the U.S. campuses and this trend has also added to ethnic diversity in the United States. Currently, international students make up almost 5% of all the students in the United States with about 3% of those students enrolled in undergraduate studies (Zhao, Kuh, & Carini, 2005). All together, there are about 600,000 international students currently studying in the United States at colleges and universities (Shupe, 2007). The University of Montana (UM) is not an exception. UM has seen a steady increase in international students over the last few decades (UM-FSSS, 2008). Diversification of U.S. campuses elicited intercultural exchange of ideas and resources, which has been a positive impact but it has also brought up challenges that need to be addressed.

International education is an important factor in international relations which are becoming increasingly important in a globalized world. International students facilitate the exchange of culture and resources and they also make links between different cultures (Eide, 1970; Sam, 2000; Smart, 1971; Shupe, 2007). While it is important to bring international students to the U.S. for these reasons, it is also important to provide adequate services to international students in order to help their cultural adjustment and integration into the U.S. campuses.

Faculty members and service providers on U.S. campuses are faced with challenges in terms of being able to effectively interact with individuals from other cultural backgrounds. As

one of the campus service providers, health care centers play a significant role in student's well being and quality of life. How health care professionals address the cultural barriers will affect the quality of health care services provided to international students, which in turn will affect their adjustment to the college life in the U.S. Living in a multicultural world opens a new world of opportunities to the individuals, but it should be emphasized that it also brings a set of challenges for those individuals. The cultural challenges can be especially significant for the individuals working in health care industry as they often garner sensitive personal and private information about a patient and such information is, in most cases, subjected to culture specific norms of disclosure and behavior. Living in a multicultural world requires different sets of skills for a health care professional in order to competently and effectively navigate intercultural interactions with patients. Consequently, intercultural communication competence plays a significant role in preparing the health care professional to be an effective communicator in intercultural interactions.

In this study proposal, I am hoping to address specific intercultural communication challenges that health care providers at the University of Montana (UM) face on daily basis. For my professional paper, I designed a training for health care providers at the UM Curry Health Center (CHC) that informs them what intercultural communication competence is and teaches them practical skills that will help health care professionals become more culturally competent communicators. This training curriculum achieves two goals. The first goal was to provide health care professionals with the tools to provide high quality service to all patients with emphasis on international students. The second goal was to help international students by providing primary health care that will address intercultural challenges they face, and hence ease their way into the new culture.

I will start by providing the overview and rationale for this study examining the state of the U.S. health care system, CHC services on the UM campus, and international students as a specific group that has special needs. Also, I plan to define intercultural competence and explain why it is important to talk about this subject in health care. After the overview, I will propose a theoretical framework, which was used to design the training specifying the goals and objectives. In addition, I will outline the research methodology that allowed me to design the training based on specific needs of the CHC staff. Lastly, I will detail the training curriculum needed for an effective training on intercultural communication competence for health care professionals at the UM.

Overview and Rationale

The University of Montana had approximately 770 international scholars and students from over 70 different countries as of fall 2008 (UM-FSSS, 2008). A total of 13,858 students make up UM's student body and thus a little over 3% of University students are international students (UM-About UM, 2008). On a national note, international students make up almost 5% of all the students in the United States (Zhao, Kuh, & Carini, 2005).

International students at UM face many challenges in terms of culture shock, language barriers, differences in education systems and others. In order to facilitate international students' learning and adjustment to their college life in the U.S., UM has two main offices (i.e. Foreign Student and Scholar Services, and International Programs), which are in charge of all the international initiatives. While Foreign Student and Scholar Services (FSSS) assists students in dealing with culture shock through personal advising, referrals, and different community friendship programs, International Programs (IP) helps with study abroad programs and research development programs. For the study purpose, I identified international students as "individuals who temporarily reside in a country other than their country of citizenship in order to participate in international education exchange as students" (Lin & Yi, 1997, p. 473). In other words, all of the UM students who are neither U.S. citizens nor permanent residents, will be considered international students.

FSSS is responsible for many aspects of international students' welfare including admission, graduation and practical training, all of which have special requirements for international students. More specifically, the office offers consultation, and coordination between international students and scholars, and their American counterparts in order to accomplish the academic and professional objectives of international students, as well as to enhance the overall

intercultural understanding. Also, FSSS cooperates with different student groups and the Missoula International Friendship Program (MIFP) sponsoring cultural events, a speaker's bureau, and leadership opportunities for students, a community hospitality program and the annual International Food and Culture Festival. The International House (I-House) is also part of the FSSS's activities, which serves as an activity center for intercultural events on campus. The services provided by FSSS include, but are not limited to: pre-arrival and arrival assistance, orientation programs, peer assistant program, personal and academic advising, financial assistance, immigration advising, liaison with community services, educational field trips, I-House management, and others (UM-FSSS, 2008).

The second main office in charge of international initiatives, IP, is in charge of promoting and supporting the international education, scholarships and research studies, trainings, and projects that serve UM's international mission. Also, IP is in charge of negotiating agreements with external partners to foster research development opportunities. The agency also engages in interdisciplinary international programs and projects providing educational experiences for faculty and students through exchanges, grants and self-support programs. In addition, IP hosts English Language Institute (ELI) that offers English classes to international students preparing them to officially enter UM as undergraduate students (UM-IP, 2008).

In addition to FSSS and IP, international students also have access to all the other UM services available to the student body. As part of the general student services on campus, UM has a health clinic that provides medical services. Since health care is a vital part of everyone's life, most of international students will visit Curry Health Center (CHC) at least once during their college years at UM. Unlike other campus services such as career center or notary office for example, health care providers interact with international students more frequently (i.e. on daily

basis). Being an international student at UM myself, I have used the CHC services many times over the last five years. Therefore CHC, as the primary health care institution on the UM campus, deserves more attention in terms of preparedness to respond to the special needs of international students (UM-CHC, 2008). Along these lines, I believe that intercultural competence training would provide a good resource for the CHC health care professionals who work with international students on daily basis and hence who have the need for being culturally sensitive to this particular student body. Currently, UM does not have regular trainings in place that would address the intercultural competence issues on campus. Given that CHC staff interacts with international students on daily basis and that there is no regular training in place that would teach them how to navigate in intercultural interactions, there is a need to design and implement the training that would address intercultural communication competence. While the University of Montana is committed to diversification in terms of “inclusion of female, minority, and international faculty, staff and students” (UM-Office of the President, 2008, Goal I: line 6), the university has yet to implement specific steps that would accomplish these goals.

Based on my personal experience as a Public Speaking instructor, and my internship at FSSS, I came to the conclusion that UM follows what Edwards (2007) calls an *opportunistic model* of internationalization of higher education. As an intern at FSSS, I examined the existing documentation pertinent to the international student body, and I also interviewed a number of experts involved with international students on UM campus to learn more about the current state of internationalization of higher education at the University of Montana. The information I got, based on the relevant documents and interviews, indicates that the University does not have a centralized system that addresses the special needs of international students. Rather, UM follows the *opportunistic model* which is based on individual-driven instances to interact with

international students rather than planned policies of the university's administration (Edwards, 2007). In other words, UM faculty and service providers are left to cope with the challenges involving intercultural interactions on their own, which is the case in most professional jobs nationwide (Chin, 2000). This is an important factor, because it highlights yet another reason as to why it is important to provide the intercultural training to CHC staff, and hence equip them with specific tools that would help them interact with international students in a competent and effective way. Offering professional training to health providers that would raise awareness about cultural differences that affect how international patients talk about their medical ailments and behave in doctor's office will assist the service providers to offer a better care. Also, providing health care professionals with specific guidelines as to how to address intercultural communication barriers will help better understanding between service provider and patients.

According to the CHC mission and vision statements, the clinic values excellence and adheres to the highest ethical standards. Also, the mission statement points to the CHC's commitment to the ongoing professional development. In the vision statement, the center indicates that they value diversity and that mutual respect is their norm (UM-CHC, 2008). In addition, CHC highlights commitment to ongoing improvement in services, which is a good starting point for the planning of intercultural competence training.

Arguing for culturally competent health care in the U.S., Chin (2000) argues that despite determination by health care providers to incorporate cultural competence in their services, this discussion has been limited to the language barrier issues and hence the ability to provide bilingual services to patients. I find this problematic, because while language differences are the most obvious challenges in intercultural interactions, other cultural differences that tend to be more difficult to observe are also important. It is necessary to address cultural competence in

terms of themes surrounding cultural differences rather than purely as a language barrier, which is why addressing cultural differences is a pivotal theme in my study proposal. On this note, I would also like to point out that international students who join U.S. universities have to pass a standardized English exam in order to prove that they are fluent enough in English to be able to attend an English speaking university. Having this additional information in mind, I would like to add that although it is important to take into consideration the language barrier between international students and service providers on campuses, the language barrier does not present the main obstacle in intercultural interactions at UM. On the contrary, understanding the underlying cultural assumptions about healthcare provider-patient relationships, and being able to navigate in such intercultural interactions effectively becomes a crucial issue..

Lastly, I would like to add that I am personally and professionally invested in the topic of intercultural competence. I am interested to apply theoretical knowledge and put it into practice by providing intercultural communication competence curriculum to the service staff that would benefit from it along with international students. CHC will benefit from this training for several reasons. Nationally, internationalizing U.S. campuses calls for some new and innovative strategies to address the needs of the international student body and help their transition to a new culture. While UM increased enrollment of international students over the last few decades, it still relies on the individual-driven initiatives to respond to the challenges associated with this trend. Besides the increased emphasis on international education in the U.S., the health care system has undergone some major changes that call for intercultural competence in service. As an agency committed to excellence in service and diversity, whose staff interacts with international students on daily basis, CHC makes a great starting point for implementing intercultural training.

Theoretical Overview

International education

Since 9/11, international education has been gaining increased attention in the United States. Scholars involved in the field of international education have pointed out that international students are an important factor in international relations through the exchange of culture and resources (Eide, 1970; Lackland Sam, 2000; Smart, 1971; Shupe, 2007). Also, in recent years, western education systems have seen increased promotion of cultural diversity policies regarding teaching and learning. In addition, there is a growing trend of exporting higher education to students from non-Western countries making cultural diversity positive and favorable. In the executive summary of the Report of the Strategic Task Force on International Student Access of January 2003 (NAFSA, 2003), the Association of International Educators reaffirmed the stance that bringing legitimate international students to study in the United States and, thus, building friends and allies across the world is important to fight global threats such as terrorism.

Internationalizing U.S. campuses has brought up many challenges. One of the concerns in academia is about the impact of these developments in international education on teaching methods (Chang, 2006). More specifically, faculty members are concerned about changes in teaching methods that might have to be devised as part of the internationalization efforts, and how those changes will be implemented.

In addition to concerns regarding teaching methods, most international students are dealing with culture shock, which affects their academic performance as well as their integration into the new culture. Gullahorn and Gullahorn (1963) first proposed the W-curve of culture shock, which has since been expanded to include seven stages of culture shock. It is important to

understand the first four stages of the culture shock pertinent to international students in America, since the last three pertain to re-entry culture shock when a student returns home. Most students begin in the “Honeymoon Stage,” in which they are excited to be in a new country and interested in everything around them. They then dip to low satisfaction in the “Hostility Stage” when they miss their native country and become annoyed and angry with cultural differences. Satisfaction then begins to improve and students enter the “Humorous Stage” before ending in the “In-Sync Stage.” The amount of time taken to progress through the stages varies, so international students could be going through any of the stages at a given moment.

Concerns regarding how to adjust teaching methods to assist the learning processes of international students and to alleviate the culture shock that most international students go through are just some of the challenges facing universities as the U.S. campuses diversify. Providing culturally-sensitive health care is one of the essential elements for quality of college experience in the United States for international students.

Health care

Traditionally, the importance of cultural sensitivity in the U.S. health care system was emphasized in providing services to ethnic minority groups especially the immigrants who had cultural as well as language barriers as non-English speakers. Moving away from this trend that marked 1970s, the trend shifted in the ‘80s moving from cultural sensitivity to a cultural competence, which is more of a skill-focused paradigm (Chin, 2000). In the 1990s, the health care system changed again with more focus on management and cost containment, which raised concerns that cultural competence might be driven exclusively by market and economic forces (Chin, 2000). Talking specifically about the changes in the nursing profession, Lester (1998) indicates that “the nursing profession is affected by the same demographic and cultural changes

that are sending government agencies and private-sector businesses into a frantic search for “cultural competence” (Lester, 1998, p. 26). She further explains that a patient-centered orientation in nursing makes it a priority for nurses to become culturally sensitive to the needs of different people (Lester, 1998).

Reimer Kirkham (2003) points that the health care system in Canada is drastically changing given that patients are becoming sicker, hospital stays are shorter, and technology is more complicated while the communities are becoming increasingly diverse. Reimer Kirkham (2003) points out that discourses about diversity and the need to respond to the challenges related to the demographic changes in health care are widespread. Health care agencies and hospitals are involved in the evaluation of their staff’s intercultural competence, and some professional health programs include multicultural content in their training curriculum (Reimer Kirkham, 2003).

Defining intercultural communication competence

Before I define intercultural communication competence, I will start by defining intercultural communication as “a symbolic, interpretive, transactional, contextual process in which the degree of difference between people is large and important enough to create dissimilar interpretations and expectations about what are regarded as competent behaviors that should be used to create shared meanings” (Lustig & Koester, 1993, p. 58). This definition points to different tenets of communication in intercultural interactions, which are purposefully left vague and ambiguous since “intercultural” indicates variety of cultures that are specific to each individual culture and therefore we cannot look at intercultural competence as one clear-cut skill, but rather a set of skills.

How can we then conceptualize intercultural competence? Numerous theories of intercultural communication competence exist, each unique in its definition. I will define

intercultural communication competence according to four crucial elements: communication competence, tolerance for ambiguity, openmindedness/flexibility, and respect. In order for a person to be interculturally competent, they must first be a competent communicator. According to Spitzberg (1983), communication competence is contextual, appropriate, and effective. Communication competence is also an interpersonal impression, or based on how one party perceives the other (Spitzberg, 1983). Tolerance for ambiguity is also essential to intercultural competence (Ruben, 1976). Intercultural interactions are often ambiguous and uncertain, so the ability to interact comfortably in such situations is crucial.

Related to the ambiguity of intercultural interactions is the openmindedness/flexibility element of intercultural communication competence. Interacting with people from other cultures often involves confronting differences in behavior, values, and opinions, making openmindedness and flexibility essential. Van der Zee and Van Oudenhoven's (2000) separate openmindedness and flexibility into two dimensions of multicultural effectiveness. While openmindedness entails being open to new cultures and having the ability to see the world from another viewpoint, flexibility refers to "a capability to adjust oneself cognitively and behaviorally to new situations" (Van der Zee & Van Oudenhoven, 2000, p. 305). I view them as essentially the same since both refer to being open and adaptable in new situations. The final element in the definition of intercultural competence is respect. Various scholars suggest that respecting someone else's culture, without necessarily agreeing with all beliefs and norms within it, is essential for successful intercultural communication (Koester & Olebe, 1988; Ruben, 1976).

In the health care context, Chin (2000, p. 25-26) defines cultural competence as "a set of behaviors, attitudes, and policies that enable system, agency, or group of professionals to work

effectively in cross-cultural situations.” Also, culturally competent health care system is considered to be the one that promotes the importance of culture, the evaluation of cross-cultural relations, attention toward situations that come up as a result of cultural differences, advancement of cultural knowledge and adjustment of services to culturally specific needs (Chin, 2000).

I will end the theoretical overview with a quote by Tesoriero (2006) taken from his article about the stages of personal growth from ethnocentrism to intercultural sensitivity in Australian social work. Although the example is taken from a social work setting, it speaks about the importance of diversity, which is an important point that should also be applied in healthcare.

Diversity characterises humanity. Differences in values, attitudes, culture, ethnicity, social practices, political beliefs, sexuality, religion etc., mean that people hold many different world views and make very different meanings of life conditions. Such diversity must be appreciated, respected and integrated into social work practice. Working effectively and ethically with those who are different, for fair and just outcomes, is a long-established imperative in social work (Tesoriero, 2006, p. 127).

It is important to understand the current state of international education, the U.S. health care system, as well as what intercultural communication competence stipulates in order to understand the importance of having the intercultural training for the CHC health care professionals at the University of Montana.

Research Methods

Getting the permission to work with CHC

My motivation to work with CHC was based on several factors. First, my own personal experience using the clinic's services as an international student exposed me to some of the challenges that both international students as well as health care providers face in intercultural interactions. Second, advice given by relevant experts on campus such as the FSSS director, Effie Koehn, indicated that CHC has a need for intercultural training. And third, my own independent research about the current needs for intercultural competence trainings on UM campus as well as the current trends in the internationalization of higher education in the nation pointed me to work with CHC. My search for the client was a combination of the potential consultant search process and the third party recommendation (Lipitt & Lipitt, 1986).

Once I identified the venue, I contacted the director of CHC and scheduled an appointment explaining that I was interested in designing an intercultural training for CHC based on the organization's needs. I met with the CHC director, Dr. Dave Bell, on October 7, 2008. After the meeting, Dr. Bell promised that he would talk to the heads of departments and seek their agreement to grant me the permission. A day later, Dr. Bell granted me the official permission to go ahead with the project and hence work with CHC staff on preparation of the intercultural training (December, 2008).

Description of the context

Curry Health Center (CHC) is the primary health care service provider for students at the University of Montana. The center is divided into four primary departments: a) counseling and psychological services (CAPS), b) dental clinic, c) health enhancement, and d) medical services. In addition, the facility provides support programs and services to enhance quality of students'

life in college. Some of those services are: the student resource assault center (SARC), which provides support to the victims of sexual and/or relationship violence; and the self over substance (SOS) program, which is part of CAPS, and it provides primary and secondary substance abuse prevention. The center also organizes different events related to health issues to teach students how to deal with various stressors in college.

Medical services are the largest and the busiest sector of CHC, which employs about 50 medical professionals, and the sector is open 24/7 during the academic terms. As part of the medical services, the clinic provides primary as well as the urgent health care services for the student population. Primary health care ranges from very simple medical services such as routine annual exams and issues concerning women's health, to immunizations, health screens, and travel planning activities. CHC also offers specialized medical assistance in dermatology, podiatry, and orthopedics. Along with all of the services, the center offers a lab and X-ray screening (UM-CHC, 2009).

The dental clinic also provides wide range of services. A student can come and get fillings, root canals, simple extractions, teeth cleanings, or even crowns and bridges. Routine dental exams and check-ups are also part of the regular services of the dental clinic at CHC.

I designed the training curriculum based on the staff needs of the medical services and dental clinic. This choice helped me narrow down the training objective given that the clinic offers diverse medical services and each sector has slightly different needs in terms of intercultural competence.

Study participants and data collection methods

Medical services have staff employed at various positions including 6 staff members working in the front office/reception, 3 in medical records, 5 medical assistants, 12 registered

nurses (RNs), 6 mid level nurses (NPs/PAs), 6 doctors (MDs), 3 laboratory assistants, and 2 X-ray assistants. Dental clinic has 8 staff members out of which 2 are dentists (DDS), 2 dental hygienists (R.D.H.), 3 assistants, and one receptionist (UM-CHC, 2009).

It should be noted that all staff members have direct interaction with the students. For the research study, it is important to note that all study participants are 18 years and older. The study did not recruit participants who were minors (under age 18, per Montana law) and/or members of physically, psychologically or socially vulnerable populations.

In order to evaluate the current state of intercultural competence among health care professionals, their challenges working with international students, and to find out what the needs for such skills are, I used a qualitative survey with open-ended questions (Appendix A). A survey was chosen over personal interviews due to tight time schedules of the CHC staff members. Although the use of a qualitative survey as the primary methodology of the research project does not eliminate problems such as personal biases, memory losses, or false recollections of events, open-ended questions are still the best tool to find out more about the distinctive individual challenges that health care professionals face (Lindlof & Taylor, 2002).

For the analysis of the pre-training survey, I waited to collect all of the completed surveys and then I developed a code book using open coding (Lincoln & Guba, 1985; Lindlof & Taylor, 2006). Making a code book helped me to make sense of the research data and thus identify the overarching themes that informed me about the perceptions of the CHC medical workers about intercultural interactions and their knowledge about intercultural communication in general. Also, the open coding helped me to label the concepts found in the respondents' answers, separate them, compile them and organize them in an unrestricted way (Charmaz, 1983; Lindlof & Taylor, 2006). Besides looking for relevant concepts and overarching themes in the

respondents' answers, I also derived categories from standard demographics such as the respondent's occupation and years of employment at CHC (Lindlof & Taylor, 2006). Such categories, which were derived based on the respondents' occupation and year of employment, shed some light on differences in the level of challenges between different occupations within medical field (doctors vs. registered nurses).

Given the tight staff schedule and the lack of collective staff meetings that would allow me to administer the survey at a specific time, the CHC Director was in charge of administering the survey. Copies of the pre-training survey were distributed in separate envelopes, one envelope for the medical services staff, and the other one for the dental clinic staff. In addition, I emailed a brief description of the research study explaining the importance of the staff participation in the evaluation of the needs. Staff was given one week to complete the survey, if they chose to participate. There were no flyers, advertisements or any other form of advertisement used in the recruitment process. Also, there were no inducements before or rewards after the study. In order to respect tight work schedules of medical services' staff, the survey was designed in a way that did not require more than 20 minutes to be filled-out.

Data Analysis

I used the pre-training survey to evaluate the level of health care professionals' intercultural competence, learn about the nature of their interactions with international students, and get some specific examples of intercultural encounters between health providers and international student patients (Appendix A).

The survey consisted of seven open-ended questions utilizing qualitative research methods, which allowed me to get in-depth answers about the intercultural competence of CHC health care professionals and their interactions with international students (Beebe et al., 2004). Two questions were phrased in a closed-ended format inquiring about whether participants ever attended intercultural training and about participants' opinion about the importance of intercultural competence (Lindlof & Taylor, 2006). One question asked about participants' work experience. Out of 51 health providers at CHC who were encouraged to participate in the survey, I received 15 completed surveys or .34%, which were used in my data analysis.

The first two questions asked the participants about the length of their employment and previous experience with the trainings focused on intercultural competence. The answers indicated that on average, health care professionals have 8.12 years of work experience. Occupation of the respondents corresponds to the following brake down: one dentist, 3 dental assistants, 2 dental hygienists, 3 physicians (MDs), 2 registered nurses (RNs), 2 nurse practitioners (NPs), a radiology supervisor, and a laboratory scientist. Also, out of 15 study participants one attended instructional training focused on intercultural communication competence at another clinic in town where the participant works with migrant workers. Also, two other study participants attended the talk given by the Foreign Student and Scholar Services to international students during their orientation.

The participants' responses to the open-ended questions provided me with the valuable information about their experiences interacting with international students, and also about the perceived challenges in intercultural interactions. The third survey question was purposefully posed vaguely forcing the study participants to come up with their own evaluation about the intercultural interactions and the knowledge they have about those so the question asked: "What knowledge do you have about interacting with international students?" The answers to this question were really diverse ranging from none and not much, to having an extensive knowledge about intercultural interactions or receiving such training someplace else. Three respondents spoke more broadly about their knowledge about interacting with international students. One of them said that "treating international students gently and with respect garners the same response from them" (March, 2009). The other respondent went on to say: "it would be very difficult to have thorough understanding of each other and every foreign student's cultural beliefs, since there are so many cultures. You'd have to be an anthropologist. I do think there are some basic principles that help working with international students" (March, 2009).

Following the question about intercultural interactions, the fourth question asked participants to describe their experiences working with international students and to provide specific examples of such experiences. The examples I received varied from a language barrier experienced during intercultural interactions, to having to deal with remnants of different standards of health care among patients, to cultural differences. One respondent said that during interactions with international students he/she tries to "speak more slowly, clearly, and choose easier, simpler words to help them understand" (March, 2009). The same respondent also indicated that she/he tries to converse with international students, when he/she has time, asking the students to show their country on the map of the world in order to make them feel more

comfortable. Another respondent indicated that he/she helped international students to be more aware of the dental issues they were experiencing. Lastly, cultural differences were indicated as an important challenge during intercultural interactions. Along these lines, one of the respondents said how Native American students are culturally slower in speech and quieter.

The fifth question focused on the issues that are unique to interactions with international students. Again, the language barrier was indicated as a major issue unique to interactions with international students. The other two overarching themes unique to intercultural interactions were cultural differences and also different standards of health care in international students' home countries. This time respondents spent more time talking about actual cultural issues they have encountered in intercultural interactions and thus they talked about behavioral differences as well as differences in norms and values. The cultural issues mentioned were: differences in personal space and standards of modesty, differences in gender communication, religious beliefs, demonstrative vs. reserved demeanor, and then just not knowing what those cultural differences are and hence not being able to competently communicate in intercultural interactions.

As a follow up on the fifth question, the sixth question asked participants to describe challenging instances they encountered when working with international students. Challenging instances in intercultural encounters, which were indicated by participants, were further elaborated in specific examples. One respondent described a challenging instance in which a husband insisted on being in the operatory during the treatment of his wife. The same husband would not allow his wife to speak directly to a dentist. Another male did not want to listen to the post-operative instructions given by a female CHC staff member. In another occasion, a RN had to ask a student to end his cell phone conversation in order to take an x-ray. As a result, CHC instituted a sign that asks patients to turn off a cell phone when in the lab. Explaining how to take

a deep breath for an x-ray, or take a urine sample are some examples in which a language barrier was a big challenge. Besides language barriers, other challenging instances in intercultural interactions mentioned in the pre-training survey include less obvious challenging instances. For example, one respondent observed symptoms of cultural shock and loneliness experienced by international students during intercultural encounters. The respondent did not provide more details explaining how he/she observed this behavior except to say that some international students who are experiencing culture shock often appear anxious.

Lastly, one respondent pointed to differences in health standards that come into way of successful interactions between health providers and international patients. The respondent explained that some of the international students come from countries where health standards are very different from the U.S... In addition to the differences in health care standards, a respondent from dental clinic said that international students often lack basic oral health information. In such cases, the respondent explains, “I’m their first exposure to these ideas and trying to convey new ideas is difficult” (March, 2009). The answers provided to this sixth question regarding challenging instances experienced during intercultural interactions were the first in-depth insights into the perception of the CHC health providers about intercultural challenges and their preparedness or the lack thereof to address them.

Previous questions led to the core issue in this study, which is the understanding of intercultural competence. The seventh question asked participants to define intercultural competence. The words used by study participants to describe intercultural competence were: patience, friendliness, accepting, empathizing, respecting, effectively communicating, respecting, asking questions, and expecting the unexpected. While only one or two respondents failed to answer a couple of previous questions on the survey, five out of 15 respondents did not answer

this question about how we define intercultural competence. At the same time, it is interesting that the combination of the answers, which made an attempt to define intercultural competence, makes a perfect definition of intercultural communication competence.

The answers in the pre-training survey indicated that the CHC health providers are aware that there are tangible cultural differences they have to work with when interacting with international students. In other words, health providers understand that their international patients not only struggle with foreign language issues, but they also have different standards and expectations regarding health care. Also, the respondents' answers point out that being interculturally competent involves being able to understand those difference and to work within those difference in a competent manner. One respondent said that "the biggest elements of competence are to be patient and friendly, and to expect the unexpected" (March, 2009). Also, "to realize that no one person can be all-end-all person in every situation," but that "actual concern for the student can be felt by that student even if there is a language barrier" (March, 2009). Another interesting response asked a very basic, but yet a very profound question: "How would you interact with another human being from planet Earth? I always keep this foremost when interacting with others" (March, 2009). The answers to the seventh question pointed to ambiguity experienced during intercultural interactions, a need for respect and open-mindedness, and cultural sensitivity that requires one to be able to understand cultural differences and to work within them.

The next, eighth question built from the intercultural competence definition, asked whether intercultural skills were relevant to study participants' work position. Given that I have already provided three possible answers (i.e. Yes, no, and not sure), I received straight forward answers. Thirteen respondents thought that intercultural skills are important for their work, two

respondents were not sure whether the skills were important or not while none said that intercultural skills were not important. Out of thirteen respondents who thought that intercultural skills were important, one respondent indicated that intercultural skills were important just in terms of language issues; one respondent felt that intercultural skills are “somewhat” important, and one respondent said that such skills are often important. Lastly, one respondent felt that intercultural skills are extremely important for his/her position.

The last question wrapped up previous questions about intercultural competence and intercultural interactions asking the participants whether they felt confident to interact with international students. This question generated some interesting answers that addressed both cultural and language issues. Ten respondents said that they feel confident to interact with international students. As an example, one study participant who felt interculturally competent said that he/she treats everyone “with compassion, respect and dignity” (March, 2009). Other two participants described their intercultural competence as being able to use a sign language in order to overcome a language barrier while one respondent even consulted an online translator “Babel Fish” to look up words and phrases when talking to foreign students to enhance communication. One answer was particularly interesting linking the experiences of international students with the ones of ethnic minorities in the U.S. The respondent said:

“I feel confident, because I am [member of ethnic minority] in a non-traditional area of healthcare. I empathize with how they [international students] feel away from people, far away from home and comfort of sameness. I feel international students feel comfortable with me, because I am like them” (March, 2009).

A couple of respondents did not provide direct answer. Instead, one respondent gave a statement saying that the biggest problem is the language barrier and that while “many of the students speak some English, speaking and understanding are two different problems” (March,

2009). The other one said that he/she “never had a problem working with different nationalities” (March 2009). In addition, he/she identified with broader American values directly linking them to the notions of intercultural acceptance and hence he/she said: “This is America, that’s who we are!” (March, 2009). One respondent thought that he/she feels interculturally competent at times while one said that he/she feels usually competent in intercultural interactions. There was a participant who did not provide answer to this question. The answers provided in this question informed me about the perception of the CHC health providers of their intercultural competence and what they thought intercultural competence is.

At the end of the evaluation survey, I gave study participants an option to comment on anything else they find important for the study that was not previously mentioned. The respondents’ comments came from very different points of view about the importance of intercultural competence or lack thereof. While some respondents felt that the training focused on intercultural skills was crucial for the work they do, the others resisted a possibility for such training. One respondent indicated his/her concern asking whether this study means that the University of Montana “is attempting to become an international university at the expense of resident students” (March, 2009)? Quite the opposite point of view was expressed by the other respondent who said that all people in all professions should go through some kind of intercultural training given that “the world is rapidly shrinking and we need to sensitize each other to the various cultural differences that could possibly help prevent strained relations, miscommunications and 3rd world war” (March, 2009). Also, another respondent suggested that the burden of intercultural competence lies primarily with an international student. He/she specifically said:

“If the person who is from another culture attempts to understand the way the U.S. culture behaves, it makes it easier for everyone. I haven’t lived in their country so I don’t have the first hand experience of how their culture works. Do they have classes to learn about U.S. culture and customs?” (March, 2009).

On the other hand, one study participant noted that being able to effectively communicate is of primary importance in the medical field, especially in the areas of mental health and sexuality issues. Here was an observation made about how it would be impossible to learn and know every single detail about every culture, but that some basic information about intercultural competence would be useful. Lastly, one respondent reflected on universal human values reiterating that “first and foremost, treating each person as an individual rather than as a foreigner will go a long way in solving any problems that arise” (March, 2009). Overall, the respondents’ answers indicated a wide range of experiences working with international and minority students. While some respondents felt strongly about the importance of intercultural communication skills in health care profession, the others were not fully convinced that they would benefit from a training focused on intercultural communication competence.

Summary

The pre-training survey provided me with the useful insights about the perception of health care providers of their intercultural competence, direct experiences from intercultural interactions as well as the perceived intercultural challenges. A majority of respondents have been employed at CHC for longer period of time. On average, study participants have 8.12 years of work experience at CHC. Given that the pre-training survey included medical services and dental clinic, respondents consisted of physicians, RNs, NPs, dental hygienists, dental assistants, lab staff, and a dentist. Despite the fact that most of the respondents spent a long time in health

care industry only one out of 15 participants attended a training focused on intercultural competence, which was held at a different clinic.

The pre-trainings survey was designed in a way to provide some insights about the CHC staff's experiences interacting with international students and perceived challenges in intercultural interactions. My goal is to learn more about the staff at CHC in order to design a training that would not only discuss general guidelines about intercultural competence, but would address specific needs of the CHC staff in terms of challenges experienced during intercultural interactions between the staff and international students.

Based on the answers, there is a pretty wide range in terms of how health providers perceive their knowledge about intercultural issues and ability to navigate competently in intercultural interactions. While some respondents felt very confident to interact with international students, the others felt ambivalent and somewhat unsecure about the meaning and relevance of intercultural communication differences. One thing that was in common with all the respondents is that, in general, they use common sense to deal with intercultural differences. In other words, they do not apply specific principles that were attained as part of a focused training on intercultural competence; respondents use their own ethical principles that guide them through intercultural interactions.

The language barrier was reported to be one of the biggest challenges in intercultural interactions. In terms of cultural challenges, respondents reported issues such as differences in health care system, gender communication, differences between reserved vs. expressive demeanor, and differences in personal space and modesty. In terms of cultural sensitivity the important themes that emerged from the respondents' answers were: treating international students with respect regardless of cultural differences, showing interest and curiosity about a

patient's home country, having patience to explain medical issues to international students, being aware of cultural differences, and showing empathy and compassion towards international patients.

While most respondents believe that it is important to possess intercultural competence skills in order to be able to competently interact with international patients, there were few respondents who felt that the burden of having such skills lies with international students rather than with health care providers at UM. Also, reported intercultural challenges, both language barriers and cultural differences, demonstrated that the health providers at CHC are aware that intercultural encounters can be ambiguous and sometimes uncomfortable. On the whole, despite the fact that a majority of the CHC staff has not received the training focused on intercultural competency, most of them thought that intercultural interactions deserve special attention and that having intercultural skills is important for their profession.

I plan to address the issues raised in the pre-training survey by sharing them with trainees at the beginning of the training and pointing to commonalities between the staff's experiences. In addition, I will offer different examples of the challenges in intercultural interactions that will address the simplest misunderstanding as well as the more subtle ones that are harder to be observed. By providing wide range of intercultural challenges, from the simple ones to the less conspicuous ones, I will be able to respond to the different trainees' needs.

Curriculum Design

Beebe, Mottet and Roach (2004) emphasize the three domains of learning: cognitive, affective, and psychomotor. The cognitive learning domain focuses on attainment of facts and information. The affective domain focuses on changing or reinforcing one's feelings, attitudes, and motivation while the third, psychomotor domain, focuses on improving one's behaviors or skills. My training goals were identified based on these three domains (i.e. cognitive, affective and psychomotor).

Cognitive, affective and psychomotor goals

The cognitive goal of the workshop is to have the participants be able to name and describe the four components of intercultural competence. As a result of the training, health care professionals will be able to name and describe the four components of intercultural competence (i.e. communication competence, tolerance for ambiguity, openmindedness/flexibility, and respect). This is the most important goal, because it is important that health care providers understand that intercultural competence is not a clear-cut and straightforward formula that can be applied in every situation. On contrary, I would like to inform health providers that intercultural competence consists of these four qualities that should be applied in intercultural interactions and used as guidelines for continuous personal growth in terms of cultural sensitivity. The goal will be measured by a post-training survey, which asks trainees to identify the four intercultural competence skills (Appendix B). The trainees' answers provided to this question will ensure that my cognitive goal for this training is specific and attainable.

The second, or affective goal, is that trainees will gain an appreciation for intercultural sensitivity allowing them to move from ethnocentrism to ethnorelativity. In other words, trainees will be able to acquire intercultural sensitivity and appreciate cultural differences between their

own cultural norms and those of international patients. I will encourage trainees to gain appreciation for intercultural sensitivity throughout the training; during the lecture part as well as during the discussion and role play parts. Throughout the training, participants will be able not only to discuss their thoughts on intercultural competence in general, but they will be also able to tie those theoretical discussions into their actual work experiences of intercultural encounters. I will measure the success of the affective goal by comparing the pre-training survey answers of participants to the post-training survey answers (Appendices A and B). The trainees will become more culturally sensitive and hence will gain appreciation for intercultural skills.

Finally, the psychomotor goal is that trainees will be able to apply the intercultural concepts, they have learned, by putting them into practice. To do so trainees will be engaged in role plays during which they will be faced with the actual intercultural challenges that were reported in the pre-training survey. I will evaluate the accomplishment of the psychomotor goal by observing the trainees' intercultural skills during role plays and also by analyzing the responses provided in the post-training evaluation survey (Appendix B). The trainees will be put in the role play situations in which they will be asked to apply theoretical concepts covered at the beginning of the training. Also, the role plays are based on real-life intercultural challenges experienced by the CHC health providers as documented in the survey. I will be able to observe the accomplishment of this goal by observing the trainees' problem solving abilities when presented with intercultural challenges.

Overall, successful implementation of the cognitive, affective and psychomotor goals will be measured during and after the training. The cognitive goal will be measured by the participants' ability to successfully name and describe each of the four components of intercultural competence at the end of the training. The affective goal will be assessed by

comparing the answers to the pre- and post-training questions regarding the importance of intercultural training. Lastly, the ability to achieve the psychomotor goal will be assessed by the trainees' success in acting out at least one of the components essential to intercultural competence during the training.

Setting up the training goals as observable, measurable, attainable, and specific fulfills the requirements set by Bebe et al. (2004) for having a successful training. Now that I have clarified the goals that will drive the training session, I will focus on the curriculum design, and the methods I plan to use to design the training in order to make the training a success.

Curriculum description

The curriculum of the intercultural communication competence training is prepared in chronological order. This means that the training will be offered in time sequences, specifying the exact duration of the theoretical material presented, simulations and in-group role play (Beebe et al, 2004). In addition, I will cover simpler, easier material before going over some more complex concepts. The over-arching theme of the training will be the intercultural communication competence; theoretical concepts will be covered at the beginning of the training while the practical skills will be taught through in-group role play, small group discussion, and facilitated group discussion (Beebe et al, 2004).

Using chronological order, I organized the content in a time sequence based on the task analysis, which is the first step in the training preparation. Also, covering easier intercultural concepts such as intercultural communication will serve as a transition into talking about more complex issues such as defining intercultural competence and talking about the four elements crucial for intercultural competence (Beebe et al, 2004).

I will start the training by going over the results of the needs analysis, which will allow me to connect the training material with the specific needs of the CHC health care professionals. By connecting the trainees' needs with the training curriculum, trainees will be more invested and hence motivated to participate in the training making it successful (Beebe et al, 2004). Then, I will provide an overview of the University of Montana current state of international education offering the current statistics regarding international students. As of fall 2008 there are 294 foreign scholars and 472 international students at the University of Montana (UM-FSSS, 2008). In terms of the countries students come from, the majority of the international students come from Japan, Saudi Arabia, China, Tajikistan, and Canada.

The training will start with a lecture covering the theoretical concepts of intercultural communication competence. The lecture part will cover theoretical concepts about intercultural skills, and will also provide the study participants with specific examples to clarify theory. After the theoretical concepts, participants will be able to apply the acquired knowledge. First, I will invite participants to practice the skills through role play and simulation. Second, I will encourage the participants in their attempts to apply intercultural skills by stressing out what they are doing right. Lastly, I plan to correct mistakes in the participants' performance (Beebe et al, 2004, p. 77).

After the introduction, needs analysis, and basic statistics concerning international students, I plan to show a video clip, which is an excerpt from a series of films called *Worlds Apart* that focuses on intercultural challenges between American doctors on one side, and American minority patients and patients from other countries (Worlds Apart, 2009). This particular clip, which I plan to show, focuses on an Afghan man with stomach cancer who refused chemotherapy partly due to poor communication between his doctor and his daughter

who acted as translators. When the other daughter, who has not been present during the discussion concerning chemotherapy for an Afghan man, comes with her father to confront the doctor about this issue, the doctor tries to explain the situation and tries to find the best solution. The daughter feels angry about the fact that her father has not been receiving chemotherapy while the doctor feels uncomfortable and confused about how to handle this situation. This is a good example of intercultural misunderstanding and thus provides a context to engage in discussion about possible solutions for this case. After I show the clip, I will facilitate a group discussion asking trainees to share their views as to how they would resolve this problem.

Lecture. The video clip and facilitated discussion serves as a good transition into the lecture part. The lecture will start with by providing a short overview of the current state of international education and how it has been gaining increased importance over the last five decades (Smart, 1971; Lackland Sam, 2000; Eide, 1970, Shupe, 2007). In addition, I plan to talk more about the importance of bringing international students to the U.S. campuses, including UM, since international students make an important factor in the exchange of ideas, resources and culture, and also for the U.S. economy. After talking about international education in general, I will provide a historical overview of the shifting trends in the U.S. health care industry concerning intercultural sensitivity. I plan to explain how discourse about intercultural issues in the healthcare context shifted moving from cultural sensitivity, to cultural competence, and finally settling to management and cost attainment. The most recent trend in healthcare regarding intercultural communication, which is focused on management and cost attainment, raised concerns that cultural competence will be driven only by market forces (Chin, 2000). I plan to tie these two issues, the importance of international education and cultural sensitivity in the health

care industry, providing the rationale as to why it is important to teach intercultural competence skills and thus provide interculturally competent health care.

Before defining intercultural communication competence, I plan to briefly touch on the culture shock experienced by international students focusing on the first four phases of the culture shock. The first four phases of the culture shock take place in a foreign country (i.e. America) while the last three phases deal with the re-entry shock that takes place in the students' home country (Gullahorn & Gullahorn, 1963). Explaining to the trainees the kind of challenges international students experience as a result of studying in a foreign country will give them a broader picture of the issues involved in intercultural encounters. Finally, the last part of the lecture will discuss how we can define intercultural communication competence.

I will start defining intercultural competence by explaining how there is no one specific definition, but that numerous definitions exist. The reason for having so many definitions about intercultural competence is that intercultural competence most times is rather vague and ambiguous and as such it is impossible to define it in simple terms. Instead of trying to define intercultural communication competence in a clear-cut definition, we should rather think about intercultural competence as a set of skills and moreover as an awareness and sensitivity towards cultural differences. After explaining the main premise of intercultural communication competence, I will define intercultural competence according to four crucial elements: communication competence, tolerance for ambiguity, openmindedness/flexibility, and respect. Then, I will explain the importance of each of the four dimensions going into details about what they represent.

I will explain that the first dimension of intercultural communication competence, which is communication competence, is contextual, appropriate and effective (Spitzberg, 1983). Going

back to what I said about intercultural communication competence often being vague and ambiguous, I will relate it to the second dimension (i.e. tolerance for ambiguity) explaining that tolerance for ambiguity is an essential dimension of intercultural communication competence (Ruben, 1976). Besides being a competent communicator and having tolerance for ambiguity, I will explain how it is also important to be openminded and flexible in intercultural encounters (Van der Zee & Van Oudenhoven, 2000). Given that coming from different cultures often entails having different moral values and worldviews, it is important to be flexible and open-minded in situations that might involve confrontation. The last crucial element of intercultural communication competence is respect. Respecting someone else's culture without necessarily agreeing with that person is essential for having a successful intercultural exchange (Koester & Olebe, 1988; Ruben, 1976).

At the end of the lecture, now that the trainees were introduced to the main concepts of intercultural communication competence, I will offer Lustig and Koester's (1993, p. 58) definition of the intercultural communication that defines it as: "a symbolic, interpretive, transactional, contextual process in which the degree of difference between people is large and important enough to create dissimilar interpretations and expectations about what are regarded as competent behaviors that should be used to create shared meanings." The definition will tie the lecture material together emphasizing that intercultural communication competence is purposefully defined as vague and ambiguous due to different tenets of communication in intercultural interactions.

Practical tips and role play. The second session of the training will focus on the specific needs of international students. Also, I plan to offer some practical tips on how to deal with intercultural challenges. I will start by explaining that international students have to adjust to

being away from home as well as to the U.S. academic expectations to a much higher degree than the U.S. students (Arthur, 2004). Besides cultural challenges (Arthur, 2004; Lustig & Koester, 2006; Rambruth & McCormick, 2001), international students also have to deal with a language barrier (Collingridge, 1999; Lee, 1997; Spencer, 2003). I will explain to the trainees the importance of being aware of these challenges experienced by international students, because the challenges affect international students' behavior, which can be often misinterpreted as just another cultural difference.

As for the practical guidelines, it is important to consider not only the language barrier, but also to pay attention to patients' non-verbal signs, show flexibility and openmindedness, and to have patience. Some tips to enhance understanding of international students include: 1) try speaking slowly when communicating with international students, especially from the ones coming from very different cultures, 2) keep communication simple and straight-forward without inclusion of slang words, 3) use open-ended questions, 4) ask and encourage questions, 5) look for non-verbal cues, do not touch patients on the shoulders, arms, back or lap, 6) paraphrase your question, if you see that your international patient looks confused, 7) use humor judiciously, and 8) be patient and open-minded (Osa, Nyana, & Ogbaa, 2006).

Besides the language related issues, it is important to create an inviting and comfortable environment for your patients. When talking about the classroom environment Lee (1997) emphasized the need to create a comfortable atmosphere for international students to ask questions and participate in discussion. The same can apply to a health care setting given that international students face the same cultural and language related anxiety. One way of creating a more inviting and comfortable environment for international students is to listen closely when the students are speaking and make an educated guess as to what they said, rather than asking

them to repeat it. If you keep asking an international student to repeat what he/she said, this may create an uncomfortable situation for them and push them to be even more reserved. If you think that an international student did not understand you correctly even after you rephrased what you are trying to tell him/her, you can always write it down on a piece of paper and have them read it. In order to assist international student patients with listening abilities, health care providers should speak slowly and clearly (Collingridge, 1999; Lee, 1997).

In addition to language related issues, non-verbal cues, and openmindedness, I will point to the importance of being aware of the U.S. definition of health since different cultures have different understanding of the health and its importance (Kerns, Meehan, Carr & Park, 2003). I will recommend the CHC health providers to find out what a patient's definition of health is and what his/her health care expectations are. For example, Fagerli, Lien, Boten and Wandel (2005) indicate that minority patients in Norway require more time, and also lack basic knowledge about how body functions. Being aware of the cultural differences in health care expectations will assist better understanding between a health provider and his/her patient.

I plan to emphasize that health beliefs tend to be coherent with cultural beliefs and traditions and as such standard medical practices in other cultures tend to incorporate those traditional values. These differences in medical practices, which are subjected to cultural norms, make it a prerogative for a health care provider to consider the patient's definition of health before starting with a medical treatment. For example, a health provider might enter into a conflict with your patient as a result of poor communication and misunderstanding; the patient might not follow up with the prescription or even not show up for the next appointment. Having the understanding of an international student's definition of health care will lead towards a better overall understanding and hence successful encounter (Kerns et al, 2003).

When it comes to cultural differences, it is also important to consider differences in power relations. Equality is expressed and measured by different standards following cultural traditions. In some cultures, equality is interpreted by sameness. As a result, social informal interactions usually emphasize common traits, shared beliefs and values while the same interactions deemphasize differences and dissonance. This kind of behavior organizes the context of social encounters as the one searching for consensus and avoiding conflict and open confrontation. In the West, U.S. included, health care providers tend to renounce asymmetry of power relations typical for the medical practice when it comes to encounters between a patient and a health care provider. Nevertheless, symmetrical power encounters in medicine are more likely to be found in local cultural interpretations according to the cultural norms of equality (Fagerli et al., 2005). In other words, what might be perceived to be an egalitarian medical treatment in the U.S. does not necessarily translate into a foreign culture, because the standards for evaluating equality are subjected to cultural norms. It might work better if you, as a health care provider, maintain the authoritarian attitude, because your international student patient might feel more comfortable if you acknowledge the asymmetrical power relations that are present in the healthcare setting. Of course this will not work well with all international students, but it will be useful as a general guideline that you can employ when you assess that you need to.

Now that I have covered the language related issues and provided some guidelines for how to competently interact in intercultural encounters, I would like to offer some strategies that health care providers can use to resolve intercultural challenges. Leiniger (1991) prescribes three methods for overcoming intercultural health care problems, which are: cultural care preservation, cultural care negotiation, and cultural care restructuring. The first method, cultural care preservation, allows patients to continue with their own health practices as long as they do not

interfere with their treatment regimens. For example, if a Chinese student wants to take his/her herbal tea in addition to medical prescriptions, you may want to allow him/her that.

The second model, cultural care negotiation, is practiced when cultural care preservation does not work. In such situations, you may want to strike a compromise with your international patient that would be satisfactory to your patient, but would still be in compliance with the medical treatment. For example, if a Saudi male student insists on being with his wife during her operatory procedure; instead of just saying that he would not be allowed to attend the procedure because of the clinic's rules, try to explain to the Saudi student why such practice is not permitted in the U.S. health care. Also, you could offer some kind of reassurance; for example, you can tell him that you will keep him informed about the progress of the operatory procedure while he is waiting in the waiting room. While this advice may sound commonsensical, it is not something that you might automatically think of and apply, which is why it is important to be reminded that international patients do need additional reassurance because they have to live in an unfamiliar system.

In the cultural care restructuring, which is the last model, Leiniger's (1991) suggests restructuring when a patient engages in a harmful behavior after the first two models have failed. During this process a health care provider has to work with a patient in an attempt to resolve the problem and hence change patient's harmful practice. This is the most demanding model and it requires that a health care provider knows the patient's culture in depth, has true concern for the patient, and has a full commitment to work with the patient to change the harmful practice. For example, if your patient's dietary practices interfere with medical treatment; you may suggest the food that he/she can eat within their cultural dietary habits. Obviously, you would have to know what those dietary habits are and whether your patient would be willing to consider the option. In

extreme cases you may want to enhance your argument by providing a second opinion by your fellow co-worker or even a higher ranking medical worker.

After the practical tips' section, trainees will be able to use a short break before moving into the facilitated discussion in which the trainees get to final part of the training, which focuses on specific challenges experienced by the CHC health care professionals.

Facilitated Discussion. For the facilitated discussion section, I plan to use three case studies in which health providers dealt with a challenging instance during intercultural encounter (Appendices C, D and E). I used the actual experiences of the CHC trainees to devise the three scenarios in order to present them with real life challenges that are realistic to their work setting. Beebe and colleagues (2004) inform us that if the scenarios used for the training are realistic and pertinent to real life situations, learners will be more motivated to participate in that training.

The way this would work is that I would divide trainees into small groups and ask them to follow the instructions, and then play the script that I have previously given them. In addition, I would ask each group to write down possible solutions for that specific challenge. After each scenario I would facilitate a joint discussion. This would repeat three times after each scenario. My goal of the facilitated discussion, besides presenting the CHC health providers with realistic challenges, would be to point that there is no one best solution. On contrary, I will emphasize that there are many good solutions that should be drawn from the four crucial elements of intercultural communication competence as well as the practical guidelines that were covered earlier in the training. The role play and facilitated discussion will conclude the learning part of the training.

Evaluation. The final part of the training session will focus on the evaluation of the training (Appendix B). In the post-training survey, the first question will ask trainees to list the

four components of intercultural communication competence, which will measure the cognitive goal of the training. The second question will ask trainees to indicate whether they find intercultural skills to be relevant on a Likert's scale of one to five. I plan to compare the answers to this question with the answers the trainees provided in the pre-training survey (Appendix A) when they were asked to indicate the importance of intercultural skills in their work occupation. The results will measure the affective goal and thus will tell me whether trainees gained appreciation for intercultural sensitivity. Lastly, I will ask trainees to inform me what part of the training they found the most useful. I am hoping to get detailed feedback from trainees and further improve the training material making it even more tailored to the specific needs of health care providers.

The evaluation is a necessary part of the training as it provides important insights into the success of the training, relevance of the material presented, and an appreciation or the lack of thereof among participants (Beebe et al., 2004).

Making the training successful

Given that CHC staff members are adult learners, the training session will include a combination of teaching methods including: lecture, role play, and facilitated group discussion (Appendix F). By implementing a variety of training methods, I will be able to involve trainees as well as to cover the relevant information pertinent for gaining intercultural competence skills (Beebe et al., 2004). In addition, learning from the pre-training analysis about the real needs of the CHC staff regarding intercultural interactions, I was able to tailor the training curriculum to those specific needs and hence increase trainees' motivation for participation in the training. As a result, that training will lead to the trainees' satisfaction and accomplishment by being more culturally sensitive to the needs of their international student patients.

The four components of intercultural competence will be covered during the lecture, which will allow me to cover more information in a short amount of time. In addition, I incorporated several engagement strategies to encourage trainees to reflect on and interact with the information they will receive (Beebe et al., 2004). Showing a video prior to the lecture will enable the CHC staff to discuss elements from the video and tie it into the lecture aspect later in the training.

Also, I utilized the actual health professionals' encounters with international students and hence developed project-based learning opportunities for trainees to discuss. By incorporating these types of experiential activities, I plan to involve the trainees physically and psychologically in the training content (Beebe et al., 2004). Beebe et al. (2004) suggest that experiential activities engage trainees and help increase their self-confidence.

By utilizing the facilitated discussion to brainstorm possible solutions for the provider-patient challenges during intercultural interactions, I will be able to compare and contrast various answers for how to handle the real-life scenario. This type of training hopefully will allow participation from all the training participants and bring the opportunity to learn from other's experiences, attitudes, beliefs, and values (Beebe et al., 2004). These elements are derived directly from what Beebe and colleagues. (2004) call the E*D*I*T unpacking process. E*D*I*T stands for engaging in experiential activity, describing or talking about the activity, generalizing or making inferences beyond activity, and finally transferring the training experience to workplace context (Beebe et al, 2004, p. 122).

In addition, I will use Beebe and colleagues (2004) three specific techniques in order to enhance learners' motivation; help trainees to gain and maintain attention; and enhance trainees' abilities to recollect the information and skills presented during the training. Those techniques

are: set induction, stimulus variation, and closure. Set induction refers to the establishment of readiness to learn among trainees, which can be done in different ways. Some of the ways to achieve set induction are: explaining how a problem that affects one person affects everyone else, pointing to the urgency of addressing the issue at hands, telling a story that describes a problem the trainees may have, showing a video related to the problem instigating the trainees' interest, or using the statistics to show the significance of the problem (Beebe et al., 2004).

Once the set induction has been established, a trainer should focus on maintaining the interest of trainees, which is the second technique (i.e. stimulus variation). Maintaining interest of trainees' can be achieved through changing the teaching methods. Being mindful of activities and level of the trainee's involvement, self-monitoring of the training delivery style, and the time distribution are just some of the things that should be kept in mind during the training in order to make it successful. Having visual aids, moving across the room during lecture, being a dynamic presenter, and entertaining smaller breaks during a training are some of the practical tips for accomplishing stimulus variation (Beebe et al., 2004).

Lastly, closure offers an organized style and method of presentation that enables trainees to follow and retain the information easier. This technique is set to provide conclusion to one aspect of the training and make a connection to the next point. The lesson closure consists of three steps: summary of what has been discussed, point to the value of the information presented and offer some application of the material covered, and finally explain how previous lesson point relates to the next point providing (Beebe et al., 2004). The closure provides a broader picture to trainees using specific organizational methods that act as a glue to connect all the elements of the training. Here are some practical things that I plan to implement in order to accomplish the three techniques and thus make the training successful.

Set induction. CHC Director Dr. Dave Bell indicated that the year of 2009 will be especially stressful for his staff due to the major project of paper files transfer to electronic files that they are all working on. Recognizing the time limitations of the CHC staff members to spend two-hours in a training session, establishing their readiness to learn is of crucial importance. Therefore the training session will start with a video directly related to the CHC staff work experience (Beebe et al, 2004). Also, I will use specific examples derived from intercultural interaction challenges from the surveys to motivate and engage trainees.

Stimulus Variation. Beebe et al. (2004) emphasize the importance of active learning during the training session. I plan to secure the attention and motivation of health care professionals by keeping the training session active, involved and relevant. I will use a timeline in order to ensure that no training activity will last more than twenty minutes, other than those which keep trainees active, paying special attention to the lecture aspect of the training (Beebe et al., 2004).

Another key component to the stimulus variation will be the implementation of breaks and food. Maslow says that basic needs must be met before learning can take place (Beebe et al., 2004). For example, providing food and beverages to the trainees will ensure that CHC staff will not only be motivated, but well-nourished. Again, by keeping most sections of the training to the twenty-minute maximum, I plan to hold the trainees attention and keep them engaged in all aspects of the training.

Closure. As described by Beebe et al. (2004), closure involves three steps: summarizing what has been discussed, providing a psychological conclusion to what has been learned, and finally pointing the trainees to the next phase of the training. After the lecture, I plan to summarize what had been discussed by reiterating the four components of intercultural

competence and explaining that I was not providing universal solutions to the health provider-patient challenges of intercultural interactions, but rather teaching skills that would enable CHC staff to respond to those challenges on a case-by-case basis.

Offering the closure will be a transition to the project-based learning (PBL) portion of the training session where the CHC staff members will have the opportunity to implement the skills learned during lecture. I developed the three exercises that will reinforce the relevance of intercultural competence by showing the health care professionals how the new information and skills are applicable in their health center settings. Addressing the second step of closure at the completion of the PBL modules will offer more impact and clarity to the lecture portion of the training. Finally, I plan to link the elements of the lecture together with the PBL modules and introduce other resources that could be beneficial for the CHC staff. By offering small closure moments throughout the training I will be able to wrap up one section, link it to the next, and show significance between each session (Beebe et al, 2004).

Summary

The demographics of U.S. college campuses have been diversifying over the last few decades. There has been increased number of international students coming to study in the U.S. and currently, international students make up almost 5% of the U.S. student population (Zhao, Kuh, & Carini, 2005). UM has also followed the national trend with a little over 3% of the international student population on campus (UM-FSSS, 2008). Diversification of campuses in the U.S. has brought many positive developments as well as some challenges. International students are important for the exchange of ideas and resources, making links between different cultures as well as for the U.S. economy (Eide, 1970; Sam, 2000; Smart, 1971; Shupe, 2007). At the same time, diversification of campuses has brought up challenges in terms of intercultural differences. Thus, the ability to competently and effectively navigate intercultural interactions has become a crucial component of education in the U.S.

Health care plays an important role in student's well being and quality of life. Interculturally competent health care affects the quality of life of international students and, thus, it is important to address this issue in order to enable health care providers to offer interculturally competent health care and to assist international students with their cultural integration. Intercultural challenges are especially great in the health care industry, because the health care industry often garners sensitive personal and private information about a patient, which are in most cases related to cultural norms of disclosure and behavior.

I designed the training on intercultural communication competence for the Curry Health Care Center, which is the primary health care provider here at the University of Montana. Based on the pre-training survey, I was able to find out more about the specific needs of the CHC staff in terms of intercultural interactions and thus incorporate them in the training material.

Working with CHC on this project will hopefully not only help the health providers be able to effectively interact with international students, but will also raise the awareness of how important it has become to be intercultural competent in contemporary workplaces. Lastly, I would like to make a recommendation for the Curry Health Center regarding the implementation of the training program. This intercultural communication competence program is an important step for CHC in order to provide intercultural competent health care. I think that it would be useful for CHC to devise organizational goals that would incorporate policies affirming diversity, as suggested by Reimer Kirkham (2003). The integration of intercultural communication competence as CHC's core value will not only prepare its staff to competently interact with international students, but will also send a strong message about the organizations' commitment to provide equal access to all UM students, both to the CHC staff as well as to the larger UM population.

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Appendix A

Pre-Training Survey

1. What is your position at Curry Health Center (CHC) and how long have you worked at that position?
2. Have you attended training focused on how to interact with international students?
(Please Circle one) Yes No
3. What knowledge do you have about interacting with international students?
4. Describe your experiences working with international students? (please provide specific examples)
5. What issues are unique to interactions with international students?
6. Describe challenging instances that you have encountered when working with international students (please be specific)
7. How would you define intercultural competence?
8. Do you think that intercultural skills are relevant to your position as a health care provider? (Please Circle one)
Yes No Not sure
9. Do you feel confident to interact with international students?
10. Is there anything else that you would like to mention that you think is important for this theme?

Appendix B

Post-Training Survey

Directions: Please list the four components of intercultural competence and describe (in your own words) what each component means.

1)

2)

3)

4)

Directions: Please circle the number that reflects your level of agreement.

1) The skills we developed in this training program are important to me.

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

2) I will use what I learned in this training program.

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

Directions: Please comment with your opinion.

1) What part of the training did you feel was most helpful?

Appendix C

Case Study One: Gender Communication

Learning objectives:

- To analyze the cultural differences in gender roles
- To analyze the cultural differences in the communication behaviors
- To consider how these cultural differences in gender roles and communication behaviors affect the handling of patients' complaints

The case

A male student from Saudi Arabia walks into your office with his wife who is scheduled to have an operatory procedure. He walks straight to you explaining that his wife is the patient and says that he will talk on her behalf. When you tell him that he will not be able to be with his wife during the operatory procedure he gets angry and insists on being with his wife during the procedure.

Throughout that time, the husband maintains close proximity with you closely observing your actions. He acts very suspiciously towards you and does not show any intention to change his mind about insisting to be with his wife during the medical procedure.

Discussion questions:

- What is your initial reaction in similar situations?
- What would be some of the intercultural differences to consider in this situation before you respond to this patient's complaints?
- Based on what you learned during the training, how would you incorporate the intercultural competency dimensions into your response to this patient?

Appendix D

Case Study Two: Level of appropriateness

Learning objectives:

- To analyze the cultural differences in the communication behaviors
- To analyze the cultural differences in the level of appropriateness
- To consider how these cultural differences in the level of appropriateness and communication behaviors affect your attitude towards a patient

Case study:

While you are preparing to take in a Chinese student for examination, she picks up her cell phone and starts talking while seated in the waiting room. Despite the fact that you asked her to follow you to a doctor's room, the student does not show any intention of ending her phone conversation.

As you are walking the patient to a doctor's room you ask her to end the call, but she tells you that it is her brother from China who is on the phone and that she has to talk to him. The girl then continues to talk seemingly disinterested in your reaction. While on the phone, your student talks with a high pitch tone, which seems to be distracting to other medical workers around you.

Discussion questions:

- How does this encounter make you feel?
- What did you observe about the communication style of this patient and what do you find different from your own culture?
- How would you address this problem considering the practical tips about how to handle intercultural challenges?

Appendix E

Case Study Three: Demonstrative vs. Reserved demeanor

Learning objectives:

- To analyze the cultural differences in personal demeanor
- To analyze the cultural differences in the communication behaviors
- To consider how these cultural differences in personal demeanor and communication behaviors affect the handling of patients' complaints

Case study:

You are asking an international student patient a series of questions trying to learn more about a medical problem.. However, this student provides you only with yes and no answers excluding the details. This kind of behavior is not very helpful to you, because you need to get straightforward and detailed answers in order to diagnose the medical issue at hands, especially because the medical problem seems to be invisible.

You are wondering whether your international student patient is struggling with a language barrier; whether the patient feels uncomfortable for some reason; or maybe it is something else that you are not aware of. You do not know the country of origin of this student.

Discussion questions:

- Given that your patient is not telling you much about his/her medical conditions, what kind of non-verbal cues would you want to look for in this situation that might help you to figure out this patient's behavior?
- How could you encourage the student to provide you with more information about his/her medical issues?
- What are some of the intercultural competence qualities that you think would be crucial in this situation?

Training Outline

1. Lecture

- Introduction
 - Diversification of the U.S. campuses
 - Positive impacts
 - Challenges for the college faculty and staff
- Needs Analysis
 - Diversification of the University of Montana
 - Specific needs of the CHC staff
- Video Clip (Worlds Apart, 2009)
 - Group discussion about the video
- Overview of international education in the U.S.
 - Increasing numbers of international students
 - Importance of bringing international students to the U.S.
- Overview of health care Industry
 - Cultural sensitivity
 - Cultural competence
 - Management and cost attainment
- Culture Shock among international students
 - Honeymoon stage
 - Hostility stage
 - Humorous stage
 - In-sync stage

- Defining intercultural communication competence
 - Communication competence
 - Tolerance for ambiguity
 - Openmindedness/flexibility
 - Respect

Definition of intercultural communication:

“A symbolic, interpretive, transactional, contextual process in which the degree of differences between people is large enough and important enough to create dissimilar interpretations and expectations about what are regarded as competent behaviors that should be used to create shared meanings” (Lustig & Koester, 1993, p. 58).

2. Practical tips and role play

- Language barrier
 - Speaking slowly
 - Keeping communication simple and straight-forward
 - Using open-ended questions
 - Paraphrasing your question
- Cultural sensitivity
 - Asking and encouraging questions
 - Looking for non-verbal cues
 - Using humor judiciously
 - Being patient and open-minded
 - Creating comfortable environment for your patients
 - Being aware of the U.S. definition of health vs. your patient’s definition of health
 - Keeping in mind your patient’s cultural beliefs before you start medical treatment
 - Keeping in mind differences in power relations

- Resolving intercultural challenges
 - Cultural care preservation
 - Cultural care negotiation
 - Cultural care restructuring

3. Facilitated discussion

- Scenario A
- Scenario B
- Scenario C
- Summary

4. Evaluation