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THE IMPORTANCE OF TEACHING CULTURAL COMPETENCE IN SERBIAN MEDICAL SCHOOLS – A CONCEPTUAL FRAMEWORK

Nataša Bakić-Mirić[1,2]

[1]The University of Niš Medical School, Niš, Serbia
[2]Suleyman Demirel University, Almaty, Kazakhstan
Phone:+77773194053, Email: natasabakicmiric@yahoo.com

Abstract. *Today, as Serbia becomes a more ethnically and racially diverse nation, health care providers need to respond to patients' varied perspectives, values, and behaviors about health and well-being. Failure to understand and manage social and cultural differences may have significant health consequences for minority groups in particular. The field of cultural competence is relatively new and has become a part of a strategy to reduce disparities in access to and quality of health care in the United States, Canada and Australia. This paper will discuss the importance of introducing the concept of cultural competence in Serbian medical schools.*

Key words: *cultural competence, health care providers, Serbian medical schools.*

1. CULTURAL COMPETENCE AND HEALTH CARE

Today, Serbia's population has become diverse more than ever before and this trend is expected to continue in the future. As Serbia becomes a more ethnically and racially diverse nation, health care systems and providers need to reflect on and respond to patients' varied perspectives, values, beliefs, and behaviors about health and well-being of all nationalities and ethnic groups. Failure to understand and manage socio-cultural differences of minority groups (Chinese, Hungarians, Bulgarians, Romanians, Albanians and the Romani) may have significant health consequences.

As a result, a number of factors lead to disparities in health and health care among racial and ethnic groups, including social determinants (e.g., low socioeconomic status or poor education) and lack of health insurance. Socio-cultural differences among patients, health care providers, and the health care system, in particular, are seen by health care experts as potential causes for disparities. These differences, which may influence providers' decision-making and interactions between patients and the health care delivery system, may include: variations in patients' ability to recognize clinical symptoms of disease and illness, thresholds for seeking care (including the impact of racism and mistrust), expectations of care (including preferences for or against diagnostic and therapeutic procedures), and the ability to understand the prescribed treatment (Betancourt, Green and Carrillo 2002: 12).

For this reason, the field of cultural competence in health care has emerged in part to address the factors that may contribute to racial/ethnic disparities in health care. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, actions,

customs, beliefs, and institutions of racial, ethnic, social, or religious groups. 'Competence' implies the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by communities. Hence, cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or language proficiency (Betancourt, Green and Carrillo 2002: 13). Furthermore, cultural competence fosters maximum sensitivity to cultural differences and serves as bedrock of communication competence in health care interaction (Bakić-Mirić, Gogić, Bakić 2012: 3).

So, to attain clinical cultural competence, health care providers must: (1) be made aware of the impact of social and cultural factors on health beliefs and behaviors; (2) be equipped with the tools and skills to manage these factors appropriately through training and education; and (3) empower their patients to be more of an active partner in the medical encounter (Betancourt, Green and Carrillo 2002: 10).

Organizations can do this through:

1. cross-cultural training as a required, integrated component of the training and professional development of health care providers;
2. quality improvement efforts that include culturally and linguistically appropriate patient survey methods and the development of process and outcome measures that reflect the needs of multicultural and minority populations; and
3. programs to educate patients on how to navigate the health care system and become an active participant in their care (Betancourt, Green and Carrillo 2002: 9).

1.1. Teaching cultural competence in medical schools

In 2000, the Liaison Committee on Medical Education[1] (LCME) introduced the standard for cultural competence postulating that the faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.

As a result, a research conducted in 2000 by Flores, Gee and Kastner about teaching cultural issues in American and Canadian medical schools showed interesting results. The authors contacted the deans of students and/or directors of courses on cultural issues at all 126 U.S. and all 16 Canadian medical schools. Using a cross-sectional telephone survey, they asked whether each school had a course on cultural sensitivity or multicultural issues and, if so, whether it was separate or contained within a larger course, when in the curriculum the course was taught, and which ethnic groups the course addressed. The response rates were 94% for both U.S. (118) and Canadian (15) schools. Very few schools (U.S. = 8%; and Canada = 0%) had separate courses specifically addressing cultural issues. Schools in both countries usually addressed cultural issues in one to three lectures as part of larger, mostly preclinical courses. Significantly more Canadian than U.S. schools provided no instruction on cultural issues (27% versus 8%; p =.04). Few schools taught

[1] Liasion Committee on Medical Education (LCME) is a nationally recognized authority for medical education programs leading to the MD (Medical Doctor) degree in the US and Canadian medical schools.

about the specific cultural issues of the largest minority groups in their geographic areas: only 28% and 26% of U.S. schools taught about African American and Latino issues, respectively, and only two thirds of Canadian schools taught about either Asian or Native Canadian issues. Only 35% of U.S. schools addressed the cultural issues of the largest minority groups in their particular states. The authors concluded that most U.S. and Canadian medical schools provide inadequate instruction about cultural issues, especially the specific cultural aspects of large minority groups (Flores G., Gee D. and Kastner B. *The teaching of cultural issues in U.S. and Canadian medical schools*, accessed September 10, 2013, at http://www.ncbi.nlm.nih.gov/pubmed/10824769).

Although, no such survey has been conducted in Serbia until now[2], the Ministry of Education in Serbia and the deans of medical schools should be aware of the ever-increasing diversity of the population in Serbia and racial, national and ethnic disparities that could consequently occur in health care. Therefore, it is critically important that health care providers are educated to address issues of culture in an effective manner. For a start, cultural competence should be introduced as a preclinical course in Serbian medical schools. The second step would be the introduction of cross-cultural training in hospitals either during residency or as professional development.

Yet, Serbian medical students and professors believe that this field of core-competency education is not as important as internal medicine, anatomy or pharmacology. They believe that the field of social medicine is enough to understand how social and economic conditions affect health, disease and the practice of medicine and foster conditions in which this understanding can lead to a healthier society.

Contrary to expectation, social medicine does not teach cultural competence that is crucial for establishing a rapport with a patient coming from a different culture. What the future health care providers of Serbia should understand is that an illness in one culture is seen as such in another. Some cultures favor treatment of the whole person while others concentrate on dealing with specific symptoms. In some cultures, healthcare providers (nurse/pharmacist/doctor) will put more emphasis on the patient as a person, while in others the focus is on the analysis of the illness.

In addition, proxemics (physical distance), oculesics (eye contact), haptics (touch) and vocalics (voice patterns) vary across cultures and should be learned in order to avoid misunderstanding and insult (Bakić-Mirić 2007). Having in mind both verbal and nonverbal cues when dealing with patients from different cultures, let us take the example of Islamic culture and see what kind of issues can arise when a doctor is dealing with patients who practice Islam. In Islamic culture, women should not be touched by a man who is not an immediate family member. So if a doctor knows this, it would help him while dealing with Muslim women patients. Another practice is that people of this culture do not eat pork. As certain medicines such as insulin have pork ingredients in them, a doctor can face legal issues if he prescribes them to a practicing Muslim. However, if the doctor already has some idea of the Muslim culture, he can inform the patient about the medicine ingredients before prescribing it to him, thus avoiding such an eventuality. (Aastra Dogra, *Cultural diversity in health care*. Accessed September 12th, 2013, at http://www.buzzle.com/articles/cultural-diversity-in-healthcare.html

[2] The author will be conducting a survey on teaching cultural issues and competence in Serbian medical schools in 2014 as part of a larger project of integrating cultural competence in health care in Serbian medical schools and hospitals.

Another example, this time of the Chinese culture, brings forth the relevance of cultural diversity. According to traditional Chinese medicine, a balance of 'yin' and 'yang' is extremely important to maintain one's health. Yin represents all things that are passive and cold, while yang represents activity and heat. Both of these should be in balance if the 'Qi' or energy of the body is to be maintained to ward off illnesses. According to the Chinese, medication too can have a cold or hot effect on the body. So, when a doctor prescribes a certain medicine to them, the Chinese may not take complete medication to 'balance' out the yin and yang in the body. They may do this without informing their physician and it can deteriorate their health condition. So, if a doctor is aware of the Chinese beliefs, he would be in a better position to explain to them the importance of taking the full medicine, as prescribed by him. (Aastra Dogra, *Cultural diversity in health care*. Accessed September 12th, 2013, at http://www.buzzle.com/articles/cultural-diversity-in-healthcare.html)

Generally speaking, becoming a culturally competent health care provider is not easy. It takes a lot of patience, training and practice of those involved: educators, students and health care providers. Still, the outcomes are benevolent and rewarding. Knowing how to approach a person from a different culture will enhance a health care provider with understanding of the importance of cultural competence in any working environment. After all, effective communication between a health care provider and patents that come from different cultures is a central clinical function and one of the first steps in building a successful rapport.

2. Cultural Competence as an Integral Part of English for Specific Purposes Course at the University of Niš Medical School

All languages are ways of marking cultural identity. The language used by a particular speaker constantly refers beyond itself irrespective of the intentions of the speaker and cannot be used without carrying meaning, even in the environment of a foreign language class (Ager 1993). Therefore, English language instructors should be aware of the place of cultural competence within ESP and try, in every way, to improve students' cultural awareness and intercultural communication and cultural competence, respectively (Byran 1989).

Until now, language teaching has inevitably meant, in fact, 'language and culture' teaching 'because effective international cooperation, knowledge of other countries and their cultures is as important as proficiency in their languages and such knowledge is dependent on foreign language teaching' (Byran 1989, Byran and Sarries 1989). Thus, the role of the English language instructor is to develop skills, attitudes and awareness towards cultural values just as much as it is to build knowledge of a particular culture or country. Cultural and linguistic competence is, therefore, a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enable effective work in cross-cultural situations. Moreover, all language teaching should promote a position that acknowledges respect for human dignity and equality of human rights as the democratic basis of social interaction.

Hence, the purpose of teaching cultural competence in a compulsory ESP course in Serbian medical schools is not to try to change learners' values (as some bigoted scholars are prone to think), but to make the learners explicit about and conscious in any evaluative response to culturally different others.

The students of pharmacy and nursing of the University of Niš Medical School[3] have been learning about cultural competency and intercultural communication since 2003. They learn how to overcome stereotypes about different cultures and look at the patient as an individual whose qualities are yet to be discovered, rather than as a representative of an externally ascribed identity of other cultural, racial or national group. In other words, a future health care provider must take a proactive stance and develop sensitivity to the role culture plays in health care. The students are constantly challenged in class to simultaneously examine their own cultural biases (if any) as they learn about cultures in played-out critical incidents of clinical (Example 1) or OTC (Over the Counter) encounters (Example 2).

Example 1: Dialogue practice for students of nursing where they are drilled to understand a native English-speaking patient. After reading a dialogue, students are given a multiple choice comprehension test based on the dialogue.

Helping a Patient
Patient: Nurse, I think I might have a fever. It's cold in here!
Nurse: Here, let me check your forehead.
Patient: What do you think?
Nurse: Your temperature seems raised. Let me get a thermometer to check.
Patient: How do I raise my bed? I can't find the controls.
Nurse: Here you are. Is that better?
Patient: Could I have another pillow?
Nurse: Certainly, Here you are. Is there anything else I can do for you?
Patient: No, thank you.
Nurse: OK, I'll be right back with the thermometer.
Patient: Oh, just a moment. Can you bring me another bottle of water, too?
Nurse: Certainly, I'll be back in a moment.

Key Vocabulary:
fever
to check someone's forehead
raised temperature
thermometer
to raise / lower the bed
controls

Example 2: A critical incident in the OTC area specially designed for students of pharmacy. This is the point where students practice their understanding of verbal and nonverbal cues.

Critical incident
Scenario: Ms. Chung is obviously distressed. She has just learned that she has skin cancer.

[3] So far, to the author's knowledge, the University of Niš Medical School is the only medical school in Serbia that has addressed cultural issues in compulsory English for Specific Purposes (ESP) course for the students of pharmacy and nursing. Cultural competence and intercultural communication have been an integral part of the ESP syllabus for students of pharmacy and nursing since 2003 upon Dr. Bakić-Mirić's return from Germany where she had been specializing intercultural communication for 2 years from 2001 to 2003.

→ The pharmacist steps from behind the counter and motions Ms. Chung to a more private area. Ms. Chung indicates that the doctor was confusing when she talked about the possible side effects of the medication. The pharmacist goes over the possible side effects and explains what she should do if they occur.
→ The pharmacist observes that Ms. Chung looks confused. So, he stops and asks her if she understands. She says she does. Even though she replies that she understands, he provides a more thorough, detailed explanation. After this explanation, Ms. Chung's facial expressions reveal that she understands.
→ At one point during the conversation, the pharmacist placed his hand on Ms. Chung's hand, looked into her eyes and said in a definitive tone, *I want to help you through this*.
→ The pharmacist makes sure that his body movements and facial expressions are congruent with his words. That is, when he says he is concerned he looks concerned.
→ During the conversation, the pharmacist varies his tone, rate and volume. For example, the pharmacist noticed that Ms. Chung tended to whisper the word cancer. Therefore, he also lowered his voice whenever he used the word. The pharmacist used a soft, calm and even tone throughout the conversation as a means of comfort. (Bakić-Mirić 2007: 141)

When the incident is acted out, the following questions are inferred: *Was the approach of the pharmacist proper? Was the approach too personal? How did the pharmacist explain to Ms. Chung how to conduct the therapy? Did the pharmacist observe nonverbal signs? What were they? Was the placement of his hand on Ms. Chung's hand appropriate? How much emotion was involved? Did he overdo with nonverbal expressions? Were his nonverbal expressions congruent with his verbal ones? What about his voice patterns? What intercultural lore has the pharmacist overlooked?* In turn, the whole class discusses and compares observations from cross-cultural point of view (Bakić-Mirić 2011: 258).

At the completion of the program of study, students will be able to:

a) Understand the foundation of cultural competence: curiosity and openness, empathy, readiness to suspend disbeliefs about other cultures and beliefs about one's own.
b) Demonstrate willingness to assess the impact of one's own culture, assumptions, stereotypes, and biases on the ability to provide culturally competent care and service.
c) Understand the concept of cultural filters (or shared cultural experiences, perceptions and beliefs) as they apply to medical/pharmaceutical care in culturally diverse populations.
d) Demonstrate willingness to apply the principles of cultural competence
e) Articulate the role of reflection and self-assessment of cultural humility in ongoing professional growth.
f) Appreciate how cultural competence contributes to the practice of medicine and public health.
g) Appreciate that becoming culturally competent involves lifelong learning.
h) Demonstrate willingness to explore cultural elements and aspects that influence decision making by patients, him/herself, and colleagues.
i) Demonstrate willingness to collaborate to overcome linguistic and literacy challenges in the clinical and community encounter.
j) Appreciate the influence of institutional culture on learning content, style, and opportunities of professional training programs. (*Competence Education for*

Students in Medicine and Public Health, Report of an Expert Panel. Accessed September 12th, 2013 at http://www.asph.org/UserFiles/11 278%20CulturCompet %20Interactive%20final.pdf)

Finally, the future pharmacist, nurse and/or doctor should realize that the knowledge of cross-cultural patient care has the potential to improve communication between the health care provider and the patient, increase patient satisfaction with the provider during the encounter, increase patient cooperation with drug therapy plans, improve the quality of care and enhance patient health.

2.1. The role of the instructor

The role of the ESP instructor is to not only teach but also to help students see relationships between their own and other cultures, help them to become interested and curious about otherness and an awareness of themselves and their own cultures seen from other people's perspectives. Accordingly, in order to develop the cross-cultural dimension in Serbian lecture halls, the ESP instructor should map out pointers for students that will make them grasp the idea of cultural competence in healthcare.

The following points in teaching cultural competence should not be, therefore, considered as definite because the cross-cultural area is very wide allowing each language instructor to make his/her own set of priorities within the context. According to Byram, Grobkova, Starkey (2002: 13-15) the instructor should:

1. Teach basics of cultural competency and ground rules of intercultural communication. This is an initial step in preparing students (as future health care providers) for interaction with people of other cultures.
2. Enable them to understand and accept people from other cultures as individuals with other distinctive perspectives, values and behaviors.
3. Help them to see and understand that such interaction is an enriching experience (by showing lot of examples).
4. Teach students the knowledge of social processes (such as assimilation and de-marginalization of certain cultural groups).
5. Introduce comparing and contrasting in class. They are very important because students need to be able to see how misunderstandings can arise and how to resolve them. By comparing and contrasting two or more cultures side by side and seeing how each might look from the other perspective, students can see how unintentional misunderstandings occur in both spoken and written language.
6. Focus on skills of discovery and interaction. This means the ability to acquire new knowledge of a culture and cultural practices and the ability to operate knowledge, attitudes and skills under the constraints of real-time communication and interaction.

Finally, if the teacher manages students to be open, curious and tolerant of other people's beliefs, values and behaviors, the students will understand their own beliefs, values and behaviors better. At present day, Serbian medical students need a critical awareness of themselves and their values as well as those of other people. This will largely influence their ability to evaluate perspectives and outcomes in their own and other cultures.

3. CONCLUSION

Becoming culturally competent health care provider is not easy. It takes a lot of patience, training and practice of those involved: educators, students and health care providers. Still, the outcomes are benevolent and rewarding. Knowing how to approach a person from a different culture will enhance a health care provider with understanding of the importance of cultural competence.

Teaching cultural competence in Serbian medical schools should aim to allow the students to see, understand and learn the very foundations of cultural competence: curiosity and openness, empathy, readiness to suspend disbeliefs about other cultures and beliefs about one's own. This means not taking one's own values, beliefs and behaviors for granted, avoid assuming that they are the only possible and naturally correct ones and be able to see how they might look from an outsider's perspective who has a different set of values, beliefs and behaviors by showing the ability to de-center and think outside the box.

Furthermore, there is s a fundamental value position that teaching cultural competence should promote a position that acknowledges respect for human dignity and equality of human rights by staying in touch with the world and communicating wisely with it.

Therefore, the role of educators is to develop skills, attitudes and awareness of values just as much as it is to expand knowledge of particular culture or country and make students aware how important it is to celebrate diversity by overcoming prejudices about different people and cultures.

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