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Critical and Intercultural Theory and Language Pedagogy

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Editors

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Chapter 6

The Health Care Professional as Intercultural Speaker

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Abstract

This chapter considers points of contact and departure between intercultural language education and cross-cultural competence training in medicine. Educators in the fields of language education and medical communication have developed frameworks of intercultural competence that characterize the knowledge, attitudes, and skills that learners can draw on. While competence-based frameworks can guide curricula and audit programs, we argue that a language pedagogy also requires a process-oriented approach, a method of teaching and learning that sees the learner as a situated individual and an increasingly skilled practitioner. Medical students have the opportunity to become active and reflective practitioners in two complementary contexts: problem-based learning and the medical humanities. Additionally, medical students studying in a second or other language have the opportunity to use a variety of resources to explore how language is used in a wide range of health care contexts. Exploration of "authentic" instances of intercultural language encounters as well as online corpora of general and specific English provide an evidence base for the use of language in professional contexts and convey the everyday experience of being a patient, a caregiver, or an advocate.

Introduction

The blossoming of English into a global lingua franca has impacted on numerous aspects of professional and everyday life for millions of people. One area where professional life and everyday life interact is health care provision. In today's world, doctors, caregivers, and patients migrate between countries, institutions, and cultures. Encounters in which health is the focus of communication take place in hospitals, clinics, and the home. These encounters may involve doctors and nurses talking with patients and their family members or friends and companions, professionals discussing health care with their peers, lecturers and students engaged in medical education through the medium of English as a second language, or call-center workers transcribing oral recordings of case histories sent from a distant land. Many of these health care encounters are intercultural in the broadest sense; that is, they involve people from different countries, ethnicities, and social and professional backgrounds. Communication in general combines *transactional* and *interactional* functions: the transactional function refers to the transfer of information, and the interactional function refers to the simultaneous

construction of a personal identity and management of relationships. Health care encounters are transactional in that factual medical information is transferred from one interlocutor to another. These encounters are also interactional in that medical communication necessarily impinges on the patients' personal identity, often at its most fragile and vulnerable; medical talk constructs the hierarchical networks of doctors, nurses, auxiliary workers, caregivers, and patients; and medical advice has to negotiate the interlocutors' complex and often dissonant systems of value and belief. This chapter therefore focuses on health care providers as intercultural speakers. We focus on some of the ways in which evolving theoretical frameworks of intercultural language education might engage with the ways in which members of the medical profession have addressed cultural difference.

The Intercultural Speaker

It can be argued that any systematic approach to learning a language explicitly or implicitly constructs a theoretical speaker of that language and that these theoretical speakers differ according to the pedagogical values or curricular emphases of any given course of instruction. Thus, grammar-translation courses undertaken in the age before mass tourism implicitly theorize the learner as a reader rather than a speaker, a mute armchair traveler whose boundary crossing extends to the exploration of canonical literature in the target language. Language courses geared toward vacationers theorize the learner as a tourist, negotiating physical space and acquiring cultural capital in the form of experiences and souvenirs by way of phrasebook-assisted inquiries and remembered textbook formulae. More general communicative language courses envisage the learner as a walking thesaurus of notions and functions, differentiated according to a principle of appropriacy. Mastery of these linguistic exponents transforms the learner into an accomplisher of tasks in a manner indistinguishable from that other theoretical construct, the native speaker.

The communicative language learner is theorized as a set of linguistic and social competences; for example, he or she should be able to make requests, suggestions, or inquiries and to do so according to the conventions of politeness that are supposed to govern behavior in the target culture. Increasingly, though, the language learner has been posited as someone who understands and navigates cultures. The *Standards for Foreign Language Education: Preparing for the 21st Century* (American Council for the Teaching of Foreign Languages, 1996) proposed that learners should address the practices and products of different cultures as a way of apprehending unfamiliar cultural perspectives. Cross-cultural engagement is thus embedded into the language learning through a process of comparison and making connections between communities. The intercultural speaker in the more detailed formulations devised by Michael Byram and fellow educators such as Gerhard Neuner, Lynne Parmenter, Karen Risager, and Geneviève Zarate is a model explicitly constructing the theoretical learner as having linguistic, sociolinguistic, and discourse competence and adds to this the notion of intercultural

knowledge and skills, defined as a set of *savoirs* (Byram, 1997, 2008; Corbett, 2003; Neuner & Byram, 2003):

- *Attitudes*—openness to otherness
- *Knowledge*—how social interaction occurs
- *Skills of interpreting and relating*—the ability to relate the linguistic outputs of the other to those of the self
- *Skills of discovery and interaction*—the ability to observe, understand, and operationalize knowledge of a new culture
- *Critical cultural awareness/political education*—critical evaluation of cultural practices of the self and other (cf. Byram, 2008)

The nature of the *savoirs* has been challenged and subjected to reformulation, for example, by Karen Risager (2007), who suggests that they are less a set of characteristics of intercultural speakers and more an instrument of assessment, especially given Byram's involvement in embedding the *savoirs* into the *Common European Framework of Reference for Languages: Learning, Teaching, Assessment* (Council of Europe, 2001). Risager reshapes Byram's inventory and offers a set of what she calls "resources" that theoretical intercultural speakers should be able to draw on and adds two further items: "linguistic identity" and "poetics."

Whether the learner is envisaged as someone whose skills and knowledge are gradually being enhanced or as someone who draws on linguistic and cultural resources with ever greater effectiveness, in many respects the intercultural speakers theorized by Byram and Risager are similar; he or she is a secondary school pupil, being exposed simultaneously to the complexities of a second language and the liberal precepts of citizenship education. While Byram and Risager may be concerned primarily with devising robust curricular frameworks to encourage intercultural language learning in malleable youth, it is part of the attraction of these frameworks that they can be adapted for other circumstances and other speakers, such as business and health care professionals. These learners can be theorized as "situated speakers" whose shared concerns and communicative demands have over the past four decades given rise to the educational industry of teaching English for "specific purposes." Addressing the demands of "situated speakers" gives educators an opportunity to refine our models of linguistic and intercultural competences and skills. They also give us an opportunity to reflect on the degree to which the education of intercultural speakers is served by inventories of knowledge, attitudes, and skills.

Cross-Cultural Competence

In the United States, there has been a growing concern to develop intercultural skills generally among the undergraduate population. For example, Bok (2006, p. 249) stresses the need for all students to develop the "open-mindedness, tolerance, and respect" required for living and working in a global society. Much of the literature relating to the intercultural speaker as health care professional is specifically concerned to address the disparities in medical provision that arise

out of cross-cultural misunderstandings. Intercultural speakers are constructed as professionals in a complex "community of practice" (cf. Wenger, 1998) who need to be sensitized in order to reduce these disparities. Cross, Bazron, Dennis, and Isaacs (1989) extend the application of cross-cultural competence from the individual health care provider to the entire organization, "at every level of organization, including policy making, administration, the recruitment and training of labor, service delivery, family and communities." Their definition of intercultural competence is designed to enable each part of the organization and community to come together "to work effectively in the context of cultural differences." The need for understanding of culturally conditioned communication styles is accentuated by research that suggests that high incidences of failure among medical professionals from ethnic communities were not on the grounds of prejudice but on the grounds of candidates' nonadherence to privileged discursive strategies (e.g., Wass, Roberts, Hoogenboom, Jones, & Van der Vleuten, 2003).

The skills and attitudes that relate specifically to doctors have been extensively discussed, and medical education can be monitored to evaluate whether it addresses the sensitization of individual learners. For example, Mutha, Allen and Welch (2002) have devised a "tool kit" to determine the extent to which medical curricula include learning objectives pertinent to the development of culturally competent communication. Among the recommended learning objectives are the following:

Participants who successfully complete the curriculum will be able to

1. describe how cultural influences shape individual health behavior,
2. describe cultural differences that can influence patient–physician relationships,
3. discuss how explanations of disease etiology can differ among diverse patients,
4. identify and address cultural barriers that may affect communication in patient–physician relationships,
5. employ culturally appropriate questions that effectively elicit patient information in the clinical encounter,
6. work effectively with a medical interpreter, and
7. apply communication techniques to resolve conflicts in culturally sensitive ways.

These objectives can easily be related to the types of competence and resources formulated by Byram, Risager, and colleagues working in general intercultural language education. For example, general intercultural language education emphasizes the importance of the learner developing ethnographic skills, acting as a cultural mediator, and being aware of the differences in value and belief that affect the relationship between the self and others. Health care professionals who are intercultural speakers may draw on the anthropological literature and their ethnographic skills, for example, to observe how particular communities, such

as working-class Scottish, American, or Taiwanese males or first-generation Chinese or Vietnamese immigrants to the United States, give information about their health problems and the extent to which they will be inclined to comply with medical advice given. As Strathern and Stewart (1999) observe,

> In addition to the mode of medical training received, the value systems of individual medical students and physicians vary greatly and influence how information is transmitted and obtained. Attempting to understand the whole patient and treat the whole person who exists within a complex social nexus is one of the more insightful ways of lessening communication problems. (p. 181)

As Strathern and Stewart suggest, issues relating to attitudes and belief are central for health care professionals. In the United States, attitudes and beliefs have been interrogated with respect to parity of care. For example, Churak (2005) explores the multifactorial causes of disparity in renal transplants among minority patients, noting that individual, interpersonal, and institutional forms of racism are part of the picture:

> For example, substantial evidence exists that physicians and other caregivers unconsciously and automatically use "stereotype application," whereby a patient's age, gender, diagnosis, sexual orientation, and race/ethnicity influence the health care provider's beliefs about and expectations for that patient. The patient may unintentionally be identified by the clinician as being less deserving of treatment. Epidemiological data from minorities may indeed be applied to individual patients by clinicians in a way that reinforces marginalization. (p. 153)

Various institutions have sought to address the attitudinal and factual bases for disparity and inefficiency in dealing with patients of different cultures. For example, the University of Washington Medical Center (2007) issues guidelines to guide health care professionals dealing with different cultural groups and offers the following tips:

> The Chinese culture emphasizes loyalty to family and devotion to traditions and puts less emphasis on individual feelings. Assess your patient's kinship relationships and determine which family members are most influential in decision making. When possible, engage the whole family in discussions that involve decisions and education about care. (p. 2)

Clearly, there are dangers as well as virtues in abstracting a set of supposedly common characteristics from such a general group as "the Chinese" and projecting them onto any individual patient.

Issues of stereotyping are well recognized in the literature on culturally competent health care; for example, Betancourt (2006) cautions against broadly applying stereotypes to individuals who seem to fall into categories such as "the Hispanic patient." Teal and Street (2009) also discuss specific strategies to counteract stereotyping that they acknowledge as a natural human process. They

recommend a focus not primarily on the cultural group to which a patient nominally "belongs" but on "core cultural issues":

> Core cultural issues which physicians should be taught to recognize and assess include beliefs about gender roles, physician authority, physical space, family roles, beliefs or practices about death, religious beliefs, and explanations of disease (Davidhizar, Giger, & Hannenpluf, 2006; Rapp, 2006). Communication is also a core cultural issue with several aspects, including recognition of status (e.g., use of first names), non-verbal behaviors (e.g., the meaning and use of gestures), and communication styles (e.g., what is considered rude or overly direct speech). (p. 536)

In short, in the medical literature, we can see the extension and adaptation of debates about intercultural speakers and intercultural language education that are familiar to those in general language education. The Tool for Assessing Cultural Competence Training (TACCT, 2006), a questionnaire on knowledge, skills, and attitudes developed at the University of California, Irvine, as a tool for medical schools to assess their cultural competence training (American Association of Medical Colleges, 2006; Lie, Boker, & Cleveland, 2006), can be seen as an elaborate version of Byram's *savoirs*, Risager's "resources," or indeed a version of the *Common European Framework of Reference for Languages* devised for American medical educators. The TACCT balances the need to consider cultural predispositions against the risk of stereotyping. Users are encouraged to match the content of preclinical and clinical courses against "domains" that include the definition of cultural competence and its key aspects, the impact of stereotyping on decision making, awareness of health disparities, and cross-cultural skills, such as working with an interpreter. The extent to which any given medical course addresses intercultural competences should then be apparent.

Questioning Competence

However, even granting the utility of an extended and adapted list of intercultural knowledge, skills, and attitudes tailored to the specific needs of health care professionals, there is still a reductive element to the specification of competence as a set of inventories. Approaches to intercultural language education that are driven by inventories of resources, *savoirs*, or cross-cultural medical knowledge, skills, and attitudes may be in danger of reducing complex, situated, learned expertise to a more or less nuanced set of abstractions that are more of a metaphor for knowledge than knowledge itself. It is instructive to consider that any inventory of "competences" governing intercultural behavior is as much of an abstraction as the medieval notion of the "humors" that governed the Hippocratic model of the body. The humors were supposedly bodily fluids that had to be kept in balance for the health of the individual. Humoral theory was elaborated to explain, for example, "sexual and racial differences, character, disposition, psychological traits—in fact, every significant aspect of human life" (Porter, 2005, pp. 45–46). Porter observes that the four humors "proved wonderfully versatile

as an explanatory system" because they afforded "a neat schema with unlimited explanatory scope" (p. 47). A striking feature of this system is that apparently cognitive or affective characteristics—melancholy, anger, and even-temperedness—were made to correspond to an individual's physical makeup, appearance and behavior. As Porter (2005) observes,

> A human being was thus represented in traditional biomedicine as a complex, differentiated but integrated whole. . . . The humors formed one facet, and their disposition was reflected in the "complexion" (or outward appearance) and the "temperament"—or, as we might say, the personality. Humors, complexion and temperament constituted an interactive system, equipped with feedback loops. (p. 49)

It may seem flippant to compare Byram's *savoirs*, Risager's "resources," or the domains that make up TACCT to humoral theory. We acknowledge the utility of inventories of skills in shaping curricula, guiding assessment, and auditing the quality of courses of instruction. Yet it is precisely *because* the humors were such a successful explanatory system for so long—while being so wrong—that they are a useful test case for any other model of human psychology and behavior. At the very least, they remind us that the process of language education must necessarily be distinguished from abstracted accounts of its outcomes.

Porter (2005) recalls that Samuel Johnson defined human beings as "incorporated minds," and a definition of intercultural speakers might well be "incorporated *savoirs*." Such a notion underlies Barnett's (1994) notion of "intercultural being" and Phipps and Gonzalez's (2004) construction of the learner as "languager," that is, a learner who uses language to engage "with the whole social world" and manifest an "embodied disposition for action" (p. 29). The shift in focus from advocating intercultural communicative competence to intercultural being has several consequences. One is a shift in pedagogical focus from the auditing of knowledge, skills, and attitude to the means whereby these qualities might be fostered. Another is the shift in perception of language learners as "people with skills" to the more integrated, active and developing perception of learners as "skilled practitioners" (Phipps & Gonzalez, 2004, p. 90).

To become "skilled practitioners," learners need to be exposed to situations where they can make decisions, commit errors, reflect on their performance, and try again. In medical education, two developing areas of action and reflection are found in problem-based learning and the increasingly burgeoning field of medical humanities.

Problem-Based Learning as a Site of Action

Problem-based learning (PBL) is a relatively recent and popular innovation in the delivery of medical education. Pioneered at McMaster University in Canada, by the end of the twentieth century it was used in about half of Canadian medical schools and a quarter of American ones (David, Patel, Burdett, & Rangachari, 1999). Today it is a cornerstone in the delivery of preclinical medical education in Europe and

Asia. There are different versions of PBL, but in essence a large part of the curriculum at the preclinical level is devoted to a cycle of case studies that offer problems for the students to address in groups.

PBL is an attempt to engage students in "real-life" learning situations, and in doing so it promises to engage the learner "with the whole social world" as it relates to a medical case. A PBL cycle at Kaohsiung Medical University in Taiwan typically lasts six hours—three two-hour sessions (Chen et al., 2008). In the first session, the tutor presents the group of about 10 with a case study as a "trigger." The students make hypotheses and identify learning issues; for example, if they suspect diabetes, they might consider the regulation of glucose and insulin and complications such as hypertension. They then go off and research those topics, and, in the second session, they present and discuss their results in groups and identify further learning issues. In the final session, they present their overall findings, draw conclusions, and suggest courses of action.

The pedagogical literature on PBL exhibits similar debates to those found in the literature on communicative and task-based learning, specifically about the balance between range and depth of learning achieved, whether PBL in fact outperforms lecture-based learning, and, crucially for us here, how "authentic" the problems are (e.g., Antepohl & Herzig, 1999; Colliver, 2000). More recently, there have been calls for a move away from "paper-based" PBL to "real-patient" PBL. "Real-patient encounters," according to some research on students' perspectives (Dammers, Spencer, & Thomas, 2001; Diemers et al., 2007; Stjernquist & Crang-Svalenius, 2007), serve as "a powerful driving force for learning" and "enhance integration of theory and practice." As a result, real-patient PBL is advocated as a preparation for clinical training. Preclinical encounters with authentic case studies, according to Dammers et al. (2001), help students to acquire transferable relevant knowledge and critical appraisal skills when facing new sets of events. In addition, they also foster in students the qualities of responsibility and empathy through active engagement with real patients' problems.

The PBL approach to general preclinical education has been used to engage learners with cross-cultural issues. Betancourt (2004) suggests that

> interactive, case-based sessions that highlight clinical applications are the ideal methods for teaching cultural competence. When used selectively as the clinical scenario dictates, the skills acquired from such situations can help illuminate the patient's values, beliefs and behavior. (p. 954)

Thus, cross-cultural concepts are embedded into PBL sessions as "case-based triggers" that attempt to raise students' awareness of cross-cultural issues while avoiding the stereotyping that may come from simplistic accounts of cultural predisposition. Shields (2008) describes PBL sessions that present case studies of patients presenting with gastrointestinal complaints: an obese woman unable to pay for essential medication, an Asian woman who uses alternative therapies, and a male American war veteran with hepatitis C and alcohol-related liver cirrhosis who is addicted to salty bar snacks. The students are encouraged to think "creatively," not mechanically, around the topics of racial, socioeconomic, and

professional biases toward or against particular ethnic groups, social classes, and alternative practitioners; they are invited to consider, for example, whether questions about preferences for alternative medication might be relevant only for Asian patients. Students are invited to consider how they would work with patients who wish to combine alternative and "Western" medication, how they might influence patients whose destructive dietary regime is in some way part of their identity and socialization (e.g., as a relatively hard-drinking war veteran), and how they might involve nutritionists in patient care.

In short, the assumption underpinning PBL is that the intercultural speaker's key skills are acquired not from an exposure to a checklist of competence definitions or even from "thin," managed simulations with simple and predictable outcomes but rather from an exposure to rich, immersive educational experiences that are closely modeled on real-life case studies. The intercultural speaker is not just a "person with skills"; he or she is an increasingly skilled practitioner whose managed experiences encourage sensitivity to complexity, creativity in eliciting, and openness to possibility. PBL offers numerous challenges to students, particularly those for whom the activities that are set are culturally unfamiliar or conducted in a second or other language (e.g., Khoo, 2003; Mpofu et al., 1998). However, when conducted imaginatively, PBL offers one way of addressing intercultural issues in medicine and encouraging learners to engage in "intercultural being."

The Medical Humanities as a Site for Reflection

The degree to which a PBL session is sometimes "facilitated" or "managed" toward a predicted, socially sanctioned outcome leads us to an uncomfortable fact in intercultural communication, medical education, and, indeed, life. Some problems do not have solutions, or at least the solutions to the problems may not be easily open to generalization. Insights into the situated complexities of intercultural speaking can be gained from the growing literature by medical specialists whose memoirs offer glimpses into "their world." Gabriel Weston's (2009) *Direct Red* is a lightly fictionalized account by a female English literature graduate who crossed several borders into the competitive, male world of the medical student and trainee surgeon. One episode in her memoir can be reconfigured as a case study for PBL. As an inexperienced surgeon, she encountered profuse bleeding in an adult tonsillectomy patient. As the patient began to lose large quantities of blood, she panicked and called on a more experienced consultant for help. The experienced consultant's response—which turned out to be an abrupt and profane command to get on with the job—can be used as a "trigger" for classroom discussion. The consultant's attitude seems a far cry from the empathy earlier advocated by the very same person in a communications skills session. Indeed, Weston, angered by the consultant's response, pulled herself together and completed the operation. Later, having talked to the consultant, she reflects that, in this case, the profane refusal to give assistance was exactly the right response to have made. If the anecdote is true, it speaks

to the consultant's confidence in Weston's ability and her knowledge of just how to make Weston angry enough to continue the operation alone. We can recognize and applaud the consultant's competences as an educator and mentor, but they are difficult ones to abstract, break down, and teach.

There is perhaps space, then, in a medical education program for what Karen Risager (2007) calls the "poetics" of intercultural communication. Aspiring intercultural speakers can use memoirs, fiction, poetry, art, and the other media to prompt reflection on aspects of professional life, such as what to do in moments of panic, how to deal with conflict, how to cope with an error of judgment, and so on. These problems are open ended and not easily soluble, yet the growing field of medical humanities testifies to the need felt by many medical practitioners to engage with such issues in a creative yet rigorous manner (e.g., Evans & Finlay, 2001; Evans, Ahlzén, Heath, & MacNaughton, 2008). In a broad definition of medical humanities, Evans and Finlay argue for its importance in terms that resonate with Phipps and Gonzalez's (2004) call for critically reflective "intercultural being." Evans and Finlay (2001) call for medical educators to

> refocus on the meaning of "the human," bringing the philosophical method of critical reflection—in effect, a responsible refusal to take unexamined assumptions for granted—to medicine. . . . This approach can be taken to all the scientific and humanities disciplines which together bear upon the human patient, so that they all focus appropriately on *human values* and they all employ an appropriate common method. This approach recaptures a tradition in which arts and sciences are intertwined and in which sciences, however powerful, remain oriented within a concern for human values. (p. 8)

In medical curricula, where time for "reflection and recursion" in Phipps and Gonzalez's (2004) terms is scarce, space for the medical humanities is strongly contested, but it can be found. In the United Kingdom, since the publication of *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education* (General Medical Council, 2003), there has been an emphasis on education rather than training in medicine, and medical educators in Britain and elsewhere have sought to build bridges with colleagues in the humanities. At Kaohsiung Medical University in Taiwan, students undergo two years of general education before embarking on their preclinical training. This part of their course of study encompasses language development, including an element of literary and cultural exploration, as well as an ethical strand. At Glasgow University, undergraduate medical students can opt to take "special study modules" that, in the past, for example, have looked at a concept like the family through the lens of Plato's *Republic* (Downie, 2001). In addition, Glasgow University has a visual artist, Christine Borland, working with the Medical Humanities Unit. In one of her video installations, *Simulated Patient*, Borland (2004) turns medical communication training into art. She plays the role of a woman to whom "bad news" must be broken; real medical students are charged with revealing the diagnoses: HIV, terminal cancer,

and infertility. Each conversation unfolds in turn on a separate screen while, on the other two, the student/doctor waits silently for the interview to begin. Written instructions outline the information to be imparted or assimilated. As each encounter is repeated with two students, the differences in the students' deliveries have the effect of prolonging or alleviating the patients' agony (see Borland, 2004; Lu, 2010).

Through curricular and extracurricular activities, then, health care professionals are being encouraged to think beyond the more or less managed strictures of PBL. These courses may be embedded in an undergraduate curriculum, or they may be options taken only by a minority of students; however, they represent potential spaces for intercultural exploration and the crossing of disciplinary borders.

Evidence-Based Health Communication

PBL and reflective activities based on art, literature, communications, philosophy, and history can contribute toward the development of intercultural speakers in the medical professions by engaging them in action through structured case studies and by inviting them to reflect on less easily soluble issues through an engagement with the humanities. However, as noted earlier, the load of intercultural language education in the medical field is clearly greater when students are learning and practicing in a second or other language. In the final section of this chapter, we wish to turn to the more practical aspects of learning medicine and practicing health care in a second language.

In a recent and wide-ranging discussion of health care communication, targeted primarily at first-language speakers, Brown, Crawford, and Carter (2006) discuss various aspects of experiential learning and what they term "evidence-based health communication." Among many provocative notions raised in this book is the idea that health care professionals might learn from other professions, such as the hospitality industries, whose kinship to medicine might not be immediately apparent. Brown et al. make the point that doctors are commonly engaged in examining, assessing, and recommending courses of action to patients in situations characterized by time constraints—consultations, in other words, lasting only a few minutes where empathic connection may be seen by the professional as having a low priority, while the patient desperately seeks reassurance. In this so-called "blip culture," doctors may learn from cabin crew staff on aircraft whose "emotional labor" and "sentimental work" are deployed strategically, primarily to control others. Lest their readers become too cynical about this manufactured sincerity, Brown et al. (2006) observe that

> emotion work in health care settings is not exclusively about an economically motivated process of exchange. As Bolton (2001) argues, as social beings, emotion management by health care practitioners is a way of "paying respect with feeling"; it is a personal gift given freely, sometimes unconsciously, and sometimes without the counting of costs, and as Mann and Cowburn (2005) add, many

> practitioners felt that their emotional labour performance helped the clients cope with their own emotions. Indeed, Bolton (2001) described nurses as "accomplished social actors and multiskilled emotion managers." (p. 188)

In second-language situations, the linguistic demands on intercultural health care practitioners who are managing emotions while attempting diagnosis are even more acute. As discussed earlier, inventories of competences and useful functions are useful to teachers and curriculum designers. For example, Teal and Street (2009) offer a characterization of cross-culturally competent discourse features, including recognition of potential cultural differences:

Establishing relationship	Attend to patient discomfort Recognize negatively perceived behavior and assess cause Acknowledge others accompanying patient
Gathering information	Explore changes in the patient's life, especially for immigrants ("How is medical care different here than in your country?") Assess the patient's explanatory model for the disease and treatment Ask about tangible and community resources

The second-language learner can seize on the bland questions offered ("How is medical care different here than in your country?"), but there is little guidance here on how to accomplish "emotion work." Training in emotion work can take different guises, including explicit "textbook" training, language awareness activities, and the exploration of digitized language corpora. Conventional, textbook-based language training is increasingly supplemented by exploration of an evidence base of health care interactions and texts through reflections on recorded encounters between providers and patients (simulated or real) and analyses of language corpora.

In their standard textbook on medical communication, Lloyd and Bor (2009) give the following counsel to students faced with a distressed patient:

> Try to control your anxiety (it may be communicated to the patient), avoid rushing in with questions and give the patient an opportunity to express emotion. You can help the patient to do this through empathy, perhaps by touching the patient's hand, or using reflective comments:
>
> *"I understand that this must be very upsetting for you."*
>
> *"I can understand why you are so upset."*
>
> *"Perhaps you would like to tell me more about how you feel."* (pp. 47–48)

This potentially useful but still generic advice can be enriched by the use of resources that draw on actual intercultural encounters between health care providers

and patients. Moss and Roberts (2003) and Roberts, Atwell, Swanwick, and Chana (2008) draw on video-recorded intercultural encounters in four London general practices to demonstrate different critical incidents and communicative strategies, many of which include emotion work, such as building trust through reassurance, persuasion, negotiating agreement, and dealing with a humorous response to a serious illness. The training materials are based on discourse analyses of consultations recorded as part of the PLEDGE project (Patients with Limited English and Doctors in General Practice: Education issues; see also Moss & Roberts, 2005). Health care providers are enjoined to focus on three issues in their intercultural encounters: the patients' identification of symptoms, context, and stance. Key to success is the health care provider's willingness to listen strategically. In the following extract, the doctor allows the patient space to describe her situation, which involves a marital breakdown. The booklet that accompanies the DVD notes that, rather than asking a formulaic question such as "How do you feel about that?," the doctor creates a caring space, hands out a tissue, and gently but persistently seeks clarification (Roberts et al., 2008). When the extract below begins, the patient has already been talking for about three minutes in response to the doctor's greeting of "good morning":

P: just [.] being bullied for the last four months in the office and erm I'm going [starts crying] sorry I'm going through a marriage break-up with my husband [.] we gone through the first stage er which is the decree nisi that was on the er thirty-first of erm last month and since that day he he said he's gonna show me in the this country and he'll show me

D: he'll show you what does that mean

P: that he'll teach me a lesson

D: what does that mean

In this case, the patient's physical symptoms seem related to emotional stress in the home and at work, so the doctor elicits the nature of the problems, establishing the context and the patient's perspective before beginning to negotiate preliminary action. By creating the space for the patient to explain her situation clearly, the doctor has begun to build up a relationship of trust. As Phipps and Gonzalez (2004) attest, intercultural listening is as important as intercultural speaking.

Reflection on the discourse analysis of intercultural encounters provides a strong and immediately relevant resource for reflection by health care practitioners. Other forms of linguistic analysis can supplement and extend this kind of activity. Brown et al. (2006) consider the use of online corpora as a further evidence base to raise health care professionals' awareness of aspects of medical communication. Brown and his colleagues use corpus tools, for example, to probe a Web site called *Teenage Healthfreak* for insights into young people's conceptions of and anxieties about "normality." They observe that teenagers are disproportionately likely to use the question "Is this normal?" contrastively in relation to symptoms about which they are worried. The frequency alerts health care professionals to the "positive valuations" that young people ascribe to "being normal" (Brown et al., 2006; Harvey, Brown, Crawford, Macfarlane, & McPherson, 2007).

As more and more oral and written records relating to health care and people's experience of it become available online in a searchable corpus format, students of medicine and language will be able to explore the language that professionals and nonprofessionals use to articulate their perspectives of health and illness from both a factual, transactional angle and the more interactional angle of emotion work. The use of online corpora to interrogate aspects of language is now well established in general language studies (see, e.g., Anderson & Corbett, 2009). The following is an example of the kind of activity that can be facilitated by evidence-based study:

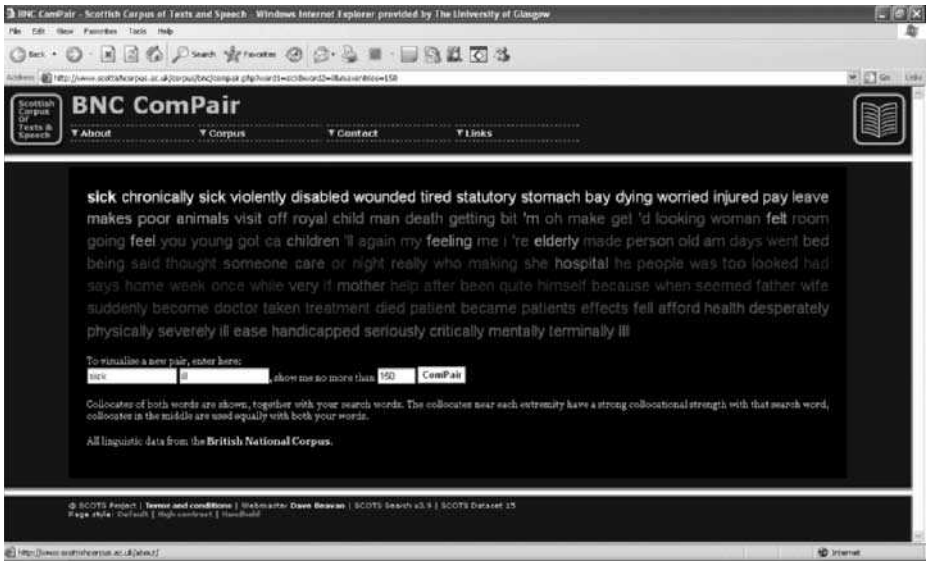
1. Go to http://www.scottishcorpus.ac.uk/corpus/bnc/compair.php.
2. Type *sick* in the first box and *ill* in the second box.

The results of this corpus search indicate those words in British English that are most closely associated with *sick* and *ill*, according to mutual information scores drawn from an analysis of the 100 million words of the British National Corpus (see the following screen shot). The results suggest, for example, that British people are much more likely to say "chronically sick" than "chronically ill." The words in the middle of the table go equally well with *sick* and *ill*. The results are suggestive in other ways. Underneath the string of collocates lie idiomatic phrases like *worried sick*, *sick and tired*, *ill at ease*, *ill afford*, and even *not quite himself*—expressions that color the experience of proficient users of the language. Such expressions can be used to articulate the emotion work that accompanies discourse on health issues, as in the following exchange from the records of the Scottish Parliament, in which a backbench member questions the health minister on the issue of personal care for the elderly:

> Dennis Canavan (Falkirk West): Is the minister aware that some old people are literally *worried sick* about how they are going to meet the costs, if and when they are taken into residential care? Will the Scottish Executive therefore implement Professor Sutherland's recommendations in full, particularly the recommendation that personal care costs should be met from public funds? Will he do that and do it soon, rather than simply follow the shabby compromise announced by the Government at Westminster? (Scottish Parliament, 2000)

The results of corpus searches have to be used with some caution. For example, the collocations suggested by the "ComPair" results include formulae such as *statutory sick leave* and *Royal Hospital for Sick Children*, which have a relatively high incidence of occurrence in the United Kingdom but may be used relatively infrequently elsewhere. The 400 million words of the Corpus of Contemporary American English, for example, show not a single instance of *statutory* preceding *sick*; the most frequent adjectives preceding *sick leave* in the American data are *unpaid*, *accumulated*, *extended*, and *accrued*, which again suggest the legalistic registers to which the term contributes (http://www.americancorpus.org). It is generally true that the results of such corpus searches confirm the situated, cultural aspects of language. If they are going to develop as skilled practitioners of

medical language, intercultural learners of English in health care contexts need to be exposed to rich, unpredictable, "natural" contexts of use and be given the space to reflect on this exposure critically and imaginatively.



Screen shot of "BNC ComPair" comparing collocates of *sick* and *ill*.

Conclusions

The intercultural speaker can be conceived as an "incorporated" set of competences and skills. The inventories suggested by Byram's *savoirs* and Risager's resources provide a useful framework for the competences expected of intercultural speakers, and this kind of framework can be adapted and extended in the light of the demands made on intercultural speakers who are health care professionals. The TACCT inventory itemizes the kinds of cross-cultural competence that are expected of graduates of American medical schools. However, as Bou-Franch and Garcés-Conejos (2003) note, with respect to pragmatics, competence "is a delicate area and it is not immediately obvious how it can be 'taught'" (cited in Brown et al., 2006, p. 186). Other intercultural language theorists advocate a view of the intercultural speaker as *skilled practitioner* or *intercultural being*, a conceptualization that involves a more holistic engagement in formation of skills through "action, reflection, and recursion" (Phipps & Gonzalez, 2004, p. 29).

In the formation of skilled practitioners, intercultural language education, like medical education, privileges PBL based closely on real-life situations. And in medical education, as in general language education, PBL sessions may be more or less managed toward predetermined outcomes. In medical situations

that involve intercultural encounters, PBL may be directed toward external clinical objectives, such as increased patient compliance with physician advice. PBL may also involve students in the simulation of *emotional labor* as appropriate to contexts such as a brief consultation or the more extensive delivery of bad news to a patient or a patient's relative. The direction of PBL toward predetermined goals, however, may suggest that certain values are beyond critical reflection. Since some problems are open ended and since values are negotiable, there is a vital place in the curriculum for the medical humanities—space where those involved in health care can reflect on their own attitudes and engage in what Teal and Street (2009) call "situational and self-awareness." The visual arts, drama, fiction, poetry, memoir, biography, and anecdotal narrative may all have a part to play in such reflective practices.

For intercultural speakers who are involved in utilizing English as a second language, an evidence base that allows access to the diverse genres used by health care professionals and their patients will increasingly act as a resource that they can draw on to enhance their linguistic repertoire. Such resources include the kind of videotaped data transcribed, analyzed, and presented by the PLEDGE project for reflection and discussion. They also, increasingly, include corpus data whose patterns of collocation and metaphor give additional insights into the ways in which different cultures address issues of health and well-being.

The professional development of health care professionals raises the stakes for theoreticians and practitioners of intercultural language education. Health care professionals work in messy and stressful environments; the demands on their time and expertise are often urgent, complex, and emotionally demanding. Educators from the fields of medicine, language, social sciences, and cultural studies variously theorize "interculturality" as a taxonomy of competences, a set of linguistic and cultural resources to draw on, a ritualized set of discourse practices to apply to predictable situations, and an all-encompassing "way of being," something akin to a fifth humor. In a crowded curriculum, the "well-rounded professional" needs to be exposed to several models of interculturality in order to compare and appraise their strengths and weaknesses.

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