Perceptions of the salience of intercultural communication in the contexts of public health and medical practice

Perceptions of the Salience of Intercultural Communication in the Contexts of Public Health and Medical Practice

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Abstract

This study investigates the significance of intercultural communication in the field of health care as described by medical doctors and medical school professors at a U.S. teaching hospital and university; practitioners in public health; and communication scholars and researchers who specialize in health communication. A Thematic Narrative Analysis of 19 extensive interviews identifies six topics that reveal similarities and differences reported by professionals across the disciplines: (1) semantic differences in the use of "communication;" (2) different conceptualizations of "culture;" (3) the importance of listening and showing respect; (4) differences in time perspectives and sensitivity to "historical trauma;" (5) culturally appropriate research methods; (6) teamwork across disciplines and cultures. Differences appear in semantics, emphasis, cultural self-awareness, and the value of empirical data and theory.

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1. Introduction

During the past 30 years, collaboration between communication scholars and professionals in the disciplines of medical practice, health education, and public health programs has greatly increased, leading to the new field of "Health Communication," a specialization that spans a wide range from doctor-patient interaction, to mass media public health campaigns. However, at present no interview-based research has been reported on how health practitioners experience and apply their understanding of intercultural communication in their daily work.

The purpose of the present study is two-fold: (1) to identify the salience of intercultural communication as identified by professionals in the fields of public health, medicine, and health communication; and (2) to share the insights gained from the experience of seasoned professionals with future health professionals and health communication scholars and researchers. Through interviews with communication researchers and health professionals the present research asks: (1) how do practitioners and researchers at the intersection of public health and communication perceive the role and significance of communication/intercultural communication? (2) how is the field of intercultural communication applied in the area of health? (3) what are perceived to be the most important applications of communication/intercultural communication in the practice of health professionals? An understanding of the relationships across their professional concerns and fields may lead to effective cooperation between intercultural communication researchers and health professionals in the rapidly expanding field of health communication.

2. Overview of the field of health communication

As health-related issues are a central concern of all human beings, communication about health and wellbeing is also a part of everyday life. Although the study of

communication has been an academic field for more than century, the first organized professional health communication specialization did not appear until the late 1960s (du Pré, 2010). Academic programs emerged only in the past 30 years (Rogers, 1996)[1]. Within the field of healthcare, the first major conference on assessing communication competence in doctor-patient interactions occurred in 1999 resulting in the landmark *"Kalamazoo Report: Essential Elements of Communication in Medical Encounters"* (Makoul, 2001).

Health communication may be defined as the study, or impact, of the communication process on health and health care delivery (Oetzel, 2009). The early subjects of health communication research focused on communication campaigns for promoting health and behavior change. Adapted from social marketing, audience segmentation was used to identify effective health communication strategies. Research on entertainment-education (EE) strategies also demonstrated positive effects in changing behavior, especially for preventing HIV/AIDS and other epidemics in developing countries (Rogers, 1996). During the past 30 years, public health shifted its focus from treating infectious diseases to preventing chronic diseases.

Clift and Vicki (1995) stated that the definition of health communication had been limited to mass mediated campaigns but they argued that its scope should be broadened to encompass all of health promotion which influences an individual's decisions, or antecedent social and cultural conditions, or public policy to change the environment supportive of healthier behaviors. Some researchers consider the role of communication in health education to include all communication.

Kreps and Maibach (2008) list six major areas for health communication research:

[1] The International Communication Association founded a Health Communication Division in 1975; the National Communication Association began a Health Communication division in 1985.

(1) health care consumer-provider interactions; (2) social support; (3) health campaigns; (4) information technologies for health education, risk prevention, and health behavior change; (5) communication practices for health care systems; (6) the impact of media and media use on health. Most of the areas are strongly connected to public health. In public health the importance of communication research has become more significant and theories of communication such as diffusion of innovation, persuasion, and social construct theories are often used to implement health campaigns and change behavior.

Provider-patient interaction continues to be a predominant area of research but the emphasis on the relationship between communication and health care delivery has broadened (Beck, et al., 2004; Thompson, 2003). In the past, health care providers often were taught to focus only on medical issues; today, communication skill development receives more attention. As the interpersonal interaction between the provider and the patient influences the entire process of health care delivery and health itself, the importance of communication skills in the interactions will continue to receive further attention.

3. Recognizing the significance of Intercultural dimensions of health care

Because culture is a system that influences our values, perceptions, communication and behavior, intercultural issues are deeply involved in all three areas of medical practice, public health, and health communication. In the area of public health, cultural concerns have been always central though, historically, the cultural focus was on developing culturally effective health campaigns, especially through the mass media, in order to change negative behaviors. For example, in some cultures, it was noted, interface communication is a more effective way to prevent disease

than through the use of mass media. This line of research, however, often failed to pay attention to culture in a deeper and pervasive sense (Airhihenbuwa, 1995). Moreover, culture was often considered as the "object" of study as it was in anthropology during the colonial era. Disease prevention programs such as HIV/AIDS or Ebola prevention, or "family planning" campaigns, were conducted in "developing" countries by those who came from "developed" countries. There were assumptions that those who need to change their behaviors are those from traditional cultures. The rise of critical postcolonial approaches has challenged the Western model in which development equals modernization and with the presumption of the superiority of West contrasted with the problems of "underdevelopment." From that perspective cultures in "developing countries" which do not fit a prevention programs design based on the Western model need to be changed (Airhihenbuwa, 1995, Dutta & de Souza, 2008, Jones & Jenkins, 2008).

In medical school education there was relatively little consideration of "culture," as the priority was placed on treating physical conditions. In early years of health communication studies, doctor-patient communication received attention, as reviewed in the Kalamazoo II Report (Duffy et al., 2004) but the "cultural" emphasis was centered on the patient's cultural background and not on intercultural communication between doctor and patient. Today it is recognized that not only do doctors and patients often have different cultural backgrounds such in ethnicity, language, age, class, region, religion, and gender but some doctors now recognize they come also from a professional medical school culture, very different from their patients.

Medical schools have come to appreciate the significance of cultural and intercultural issues in health care, but medical schools have been slow to revise curricula, in part because it is difficult to demonstrate the efficacy of increased attention to culture.

4. The Present Study

The primary method of research for this study was through face-to-face interviews of 19 professionals in the fields of public health, medicine, and health communication. Interviews were conducted over a period of 8 months, from November, 2009, through July, 2010. All professionals work in or with the Medical School at a major public university in the southwestern United States. The university hospital and medical facilities serve a wide range of diverse communities, many in rural areas, including Native Americans and speakers of languages other than English. The Medical School boasts a history of innovation in preparing medical doctors, and the affiliated public health program emphasizes community based participatory research (CBPR)[2] , to a greater extent than in conventional mass media campaigns.

The purpose of the interviews was to obtain detailed descriptions of incidents and experiences by professionals in health-related fields in which aspects of communication, culture, and intercultural communication were considered. A pre-interview survey was conducted to identify background information about the participants and to receive their consent to be interviewed. Oral interviews of approximately one hour each were conducted, supplemented in some cases by telephone and e-mail messages. Interviews were semi-structured and designed to acquire participants' narratives about their experiences (Appendix I). The interviews were recorded and transcribed.

Data were analyzed and interpreted to identify recurrent concepts and thematic patterns regarding the significance of communication and intercultural communication in context of health. The data in this initial study are too small for

2 W.K. Kellogg Foundation's Community Health Scholars Program defined *community-based participatory research* as "a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings." (Minkler & Wallerstein, 2008, p6.)

statistical comparisons, but they form the basis to identify topics for future studies with a larger data base.

The interviews consisted of explaining the purpose of the study, the researcher's position, receiving written consent for the interview to be recorded and then asking open-ended questions that invited stories that recalled professional experiences and personal reflections on the informants' professional work. Eliciting stories and reflections on those stories was thought to be the most effective approach, for it is through narratives that human beings make sense of the world and learn and transmit their culture (Bruner, 1990).

The persons interviewed (A detailed description of the background of those interviewed appears in Appendix II.) include:

(A) Medical school practitioners and faculty (MED): 7 persons, two who also had a degree in or completed several courses in communication.

(B) Public health faculty and/or researchers (PH): 7 persons, all of whom have degrees in Public health; 5 also have M.A. or Ph.D. degrees in Communication. All conduct health related research – working with culturally diverse communities – and teach at the university.

(C) Intercultural communication specialists (COM): 5 persons, of whom 3 are health related researchers and/or work and teach in the medical school.

5. Recurrent themes identified from the interviews

A thematic narrative analysis (TNA) identified six themes: 1. different perceptions of "communication" across disciplines; 2. different perceptions of "culture" across disciplines; 3. the importance of listening and showing respect; 4. time perspectives and "historical trauma;" 5. culturally appropriate research methods; 6. teamwork across disciplines and cultures.

5-1. Differing perceptions of "communication"

The meaning of "communication" often differs among those in medical practice, in public health, and for communication researchers and professors. Those who practice medicine primarily speak about provider-patient communication, the application with the longest history in health communication.

The medical school education requires no "communication course" per se, but communication receives more attention in the curriculum than in the past. In the medical school communication has mostly been included as part of the skills of "interviewing." Noting that those interview skills cannot be learned just through lectures, a medical doctor indicated that the best way to learn is through role playing with classmates, using "standardized patients" (SP), and observing actual interactions. Several courses integrate important aspects of communication, including the "Foundations of Clinical Practice" course that focuses on doctor-patient communication in clinical settings. First year medical school students start practicing doctor-patient communication with their classmates, and then interact with actors who take the role of SPs in scenarios of the kind a medical doctor may encounter. The students need to obtain medical information from the patients, and at the same time they need to build a relationship with the patients. The SPs and the faculty observe their interactions in a monitor room and then give feedback that includes noting if the students show empathy and sensitivity in addition to covering important medical procedures. After several training sessions and internships, students who fail to show communication skills, especially displaying empathy, are required to attend an additional intensive workshop. All students also observe their teachers' interaction with patients at a clinic, and they actually practice on their own under the supervision of their teachers.

An emphasis on doctor-patient communication has been a focus for the past ten

years. A communication professor who teaches communication and intercultural communication to medical doctors and medical students pointed out the changes.

> [Speaking to medical school faculty] 10-15 years ago it was very, very challenging because I'm not a physician. So they asked me why I had any expertise to talk about [communication and intercultural communication in a medical context]. But since then my sense is that physicians appreciate the importance of communication in some contexts, and when that happens they are eager to listen to you. But otherwise it is very, very challenging . . . you want to spread the word about the importance of culture and health . . .[but] it's still quite challenging. (COM)

While the medical school stresses the instrumental uses of communication, for task achievement, those from the field of communication regard the term much more broadly, with an emphasis on relationship building and maintaining. A communication professor who coordinates training programs for medical students said, "communication is all about relationships." The "relationship" theme often emerges as a part of other topics, as will be noted.

For those in public health, "communication" has been most often identified with mass media used in health campaigns, but the emphasis on CBPR and long-term sustainability, the relationships formed to develop the health campaigns, and also the sustainability of those relationships is very important. This will be more apparent in several of the themes below. Although communication is recognized differently by both public health and medicine, collaboration with communication scholars has increased but one communication professor indicated the need for greater efforts to explain to those health practitioners how and why attention to communication will

affect outcomes.

5-2. Perceptions of "culture": "culture specific" and "culture general"

Both in medical practice and in public health programs, practitioners recognize the significant influence of culture. Just as "communication" is used differently by those whose academic and professional backgrounds differ, "culture" is frequently identified differently, as well. Medical doctors speak of *"cultural competence,"* referring to the knowledge and ability to display appropriate culture specific behavior. Public health professionals speak of *"cultural humility,"* an attitude that acknowledges that the PH worker must always defer to the cultural knowledge of those of the community in which one works.

Teachers in the medical school are aware of the importance of *culture specific* knowledge, not only for patients but for medical students who come from diverse cultural backgrounds. For example, when Native American students in medical school need to dissect bodies as a part of an anatomy course, some must go through a healing ceremony. Knowledge of major beliefs about illness by groups living in an area where the students practice is indispensable. People differ in how they perceive death, birth, sex, the human body, and other beliefs, values and assumptions related to health, as well as how these may be expressed. Some people traditionally would not consider organ transplants. Medical students need to understand how Western medicine may conflict with these values. A doctor commented, "Native Americans don't want to have an organ from a dead body put into their body even if it makes them well. It may fit within *our* definition of 'well' but not within *their* definition."

In public health programs it is crucial to have *culture specific* knowledge about the community with which the PH team is working. In order to develop effective interventions, PH researchers need to learn how they can best approach the

community. For example, when PH teams try to develop AIDS prevention programs in communities where talking about sex is taboo, the PH workers may need ways to work with communities sensitively but effectively.

Mental health is an especially challenging area in which practitioners have to find out how mental health and illness are perceived in a specific community. In some communities people are not willing to talk about mental illness and do not perceive nor admit the existence of mental illness.

> . . . it helps to start to try to understand how do these people think about mental health. Do they think about it really integrated with physical health, like the holistic perspective, or separately? Where are they most likely to seek help? (PH)

Practitioners added a warning of the danger of stereotyping if they then make assumptions about patients by demographics without knowing them as individuals.

> The medical school tends to focus much more on culture specific information, meaning how do I treat a Japanese patient or an Indian patient and so on. And I think, (1), that's very useful. It also creates some challenges, because not everyone from the country is the same, and (2), you're completely ignoring the culture of the health care provider. (COM)

Likewise, intercultural stress can lead to illness, a theme often noted by those who work with refugee population, very traditional "Hispanic" communities that pre-date the arrival of the English speaking "Americans," and with indigenous communities (see "historical trauma," below). For people who have been displaced,

such as refugees, stresses are compounded. Being uprooted from home and all that was familiar is very stressful; attempting to cope with the demands of the new host culture and to make cultural adjustments that are beyond one's conscious awareness, is another layer of stress. Then, even after cultural adaptation, the refugee usually must come to terms with a new status as part of "a minority," and the attendant experiences of marginalization.

Culture general knowledge is a theme (and term) most often expressed by communication scholars who work both in public health and with the medical school. A community psychologist in public health observed:

> I guess just recognizing that people have different meanings that they give to everything in the world from mental health to health to spiritual beliefs to everything they do. So we have to recognize that our own psychology or whatever field also has values and beliefs. We have to be open to kind of mutual exchange of those [values and beliefs] – mutual learning. I think [it is essential to] recognize . . . our own situatedness in our culture in order to work with others. (PH)

Self-awareness and self-reflection tend to be ignored in medical education but similar values appear as part of cultural general knowledge.

"Intercultural communication" is a term used almost exclusively by those from the communication field. Within that field, it represents both a body of knowledge and an area of specialization. The term, "intercultural communication," however, is rarely used by health care providers or by those in public health except for those persons who have formally studied communication.

5-3. Listening and Showing Respect

The importance of listening was a significant theme noted by specialists in all three fields. Although the academic discipline of communication developed from departments of Speech, an appreciation of listening has not been a significant part of communication studies. Few schools offer courses in listening. In the context of health communication, however, listening takes on much greater significance.

> I still have to believe that listening is a skill that is under-used and undervalued. Again, it goes back to you not having all of the answers. Because if you have all the answers about another's culture, then what you're doing is basing your knowledge on stereotypes . . . . (COM)

> [Medical providers must] listen to their patients. It's *their* health, bodies, they need to be in charge. You are [just] the tool. Most doctors, practitioners, nurses, sometimes they think they are in charge. When you think you are in charge, it's hard to respect others. (Med)

> Speak less and listen more – when I first started, I did most of talking when my patients visit. I thought I should tell everything I knew. But allowing silence creates more opportunities for them not only to answer my questions but also bring up their concerns. (Med)

For those who work with Native Americans, being comfortable with silences is challenging, and as a result there is a tendency to fill in the silence with, as one PH worker said, "empty words." A researcher from a Native American community explained:

> For American Indians silence is very much accepted. Silence is the norm for us. When I knock on a door, when I go to a meeting, there is a period of silence. I'm not uncomfortable with it. I'm familiar with it. I'm accepting of it. I don't speak. As natives we are told you don't speak for the sake of speaking. You don't fill in the silence. Silence is very acceptable, time for reflection, time of pulling your thoughts together. You only speak when you have something worth sharing. Being from minority community, I'm sensitive to that issue. (PH/COM)

Intercultural communication research has long recognized the importance of "displaying respect" (Hawes and Kealey, 1981). In the present study, the significance of showing respect was closely associated with listening, intercultural competence, and culture general awareness. One PH professional credited her experience with Native American communities with clarifying the importance of showing respect in all aspects of communication. Several practitioners commented that when they go into communities they go with awareness as an outsider to have an open mind and to *learn from* the people they serve. They are conscious about how community people perceive them even after they have developed more personal relationships.

> I feel privileged to be allowed to be in native communities. I feel privileged to work with native people. But I don't feel like it's my place really. I don't know the culture and I don't know the customs. I can 'read the culture.' I can go to a ceremony. But I never will be like the people do [sic.] . . . So I keep in mind that I'm always a guest and privileged to be a guest. My hope is to leave the place and let the indigenous people do the work. (PH/COM)

> How your participation gets framed, if you come from perspective of privilege, class, race, whatever, how it's framed [is crucial]. Who you silenced and whom you did not, who are silenced and who are not, what does privilege mean? Social determinant of health fits very easily. (PH)

5-4. Time perspectives and "historical trauma"

As noted, most of the PH projects referenced in the present study are with minority communities, and because this research was conducted in the southwestern part of the U.S., much of the work is with indigenous communities as well as refugees from many parts of the world. The practitioners emphasize particular sensitivities in their work with minority groups.

> Minority cultures whether Hispanic, American Indian, or whenever it comes to reaching minority communities, historically research hasn't improved their conditions. Historically there is a mistrust of universities and research. (PH/COM)

One source of mistrust arises from being "subjects of research" who have gained little or nothing from years of study by researchers who benefited greatly from conducting the research.

> I think that [one common] type of research has often done the most injury to tribal communities. You come in, collect your data, and you're gone, and the tribe never benefits from it, never gets the results, and if they do get the results, it's in a format that is unusable by them. (PH)

There is also a deeper dimension to such distrust which may arise from the

suffering, including illness, that long pre-dates academic research. One form of this is known as *"historical trauma,"* a concept originally modeled on intergenerationally persistent trauma of Holocaust survivors after W.W.II. (Whiteback, et al., 2004). Ethnic cleansing, loss of political power, loss of language, and tradition bring psychological stress – a wounding of the soul through cataclysmic events - to Native American cross generations such that it affects the people who were not alive during the time of the event, but is transferred and translated across multiple generations (Whiteback, et al., 2004; Brave Heart, 1998; Gone, 2007; Gone, 2009).

Conducting research with some Native American communities, and trying to develop interventions, requires sensitivity to multiple layers of stress and trauma. These may be traced to major traumas of decades or centuries in the past, or they may be experienced in everyday stressors. Suspicion of outsiders who wish to conduct research about, and with, those whose collective memories are far longer than those of the outsiders poses a particular challenge for those working in all aspects of health communication. This is also a part of the challenge described below, sensitivity to culturally appropriate research methods and sharing the findings in ways that are beneficial to the communities and not just the researcher.

5-5. Culturally appropriate research methods

Closely related to the themes of attention to listening, displaying respect, and sensitivities to a history of disrespect and loss is the ability to conduct research in culturally appropriate ways. Especially in public health, people who undertake projects tend to bring research methods from academia and from methods familiar to mainstream U.S. culture. Often they go into ethnically "minority communities" or to "developing countries" and soon realize that methods that are effective when conducting research in most parts of the U.S. are not always acceptable to these

communities. A researcher in communication describes his experience.

> I really learned that taking a scale with 1 point to 5 point – "strongly agree" to "disagree" -- may work with an audience in the U.S., but may not work in a village in Thailand, or a group of people in Argentina, and finding out that maybe in those contexts stories are a better way to understand what's going on. So there's a connection to the content and the context of what you're studying in a way that only happens when you're out in the field. (COM)

Conventional surveys and interviews may work in some areas but in other areas those methods might be not useful. A practitioner who mostly works internationally said:

> A lot of people I see starting out are too bold to get information and a lot of times culturally it's not acceptable. From my experience mostly in developing countries – people are storytellers and they want to tell you their stories. So you always have to allow them the opportunities. I find the western style of interviewing very different, just get the information without letting people tell their stories. (PH)

Another PH researcher said that she and her co-workers would not ask questions until people in the community they work with wanted to tell them. Even practitioners who have a long history of working with native communities sometimes are surprised to discover how inappropriate their research methods can be. One researcher scheduled a "brain storming" session at the beginning of a research project in an indigenous community in order to evoke a variety of ideas to improve health in the community. The method that encourages ideas to be expressed

spontaneously as they occur did not fit the style of the Native Americans who are keenly sensitive to rank and role and hierarchy and the narrative style which requires more elaboration than merely shouting out an idea. People in the community took turns, in order, to tell stories one by one. Planned as a two hours session, it lasted three days.

Conducting research based on schedules of Western/academic standards is often frustrating. Different styles of meetings also bring tension for both sides. Researchers work based on an academic/Western calendar. But their plan may be delayed for several months due to the native community's traditional events.

5-6. Working across disciplines and cultures as a team

In all areas working with teams is one of the challenges in intercultural communication. In addition to working with communities or patients, practitioners work together with their colleagues. Especially when practitioners work on intervention projects internationally, they have multicultural teams which consist of people from different backgrounds and different specializations. A practitioner said that for successful projects, putting together people from different backgrounds and getting the best from each person was a challenge not to be ignored.

Teamwork among healthcare providers is crucial as physicians communicating with other doctors, nurses and practitioners affect patients' treatments and outcomes.

> Nurses and doctors – they don't talk to each other. They should, but it's tradition. Hierarchy, power, and traditionally gender, and cultural factors . . . The whole topic of teamwork is important. It's a big deal for safety but [that's] just the beginning. If doctors are respectful, the nurses tend to stay. (ME)

At the medical school where the interviews were conducted, a problem-solving curriculum for team development has begun but it appears to be limited to medical students, and not nurses.

Developing a good relationship with community and remembering that one is an outsider are essential. PH practitioners care that their projects can be sustained by communities, and try to be careful about imposing theories or research methodologies.

> My goals are very specific, and they have to do with developing an indigenous research agenda, meaning taking the best of all worlds, taking the best that western-based research has to offer, and taking indigenous knowledge and ways of knowing which, when you really look at it, are not so different. They're based on patterns of observations for the most part. And being able to have people recognize and honor the importance of both that knowledge is not hierarchical. It's not that one people or one institution has the best knowledge. (PH/COM)

How meetings are conducted may also be very different.

> Silence in [Native American] meetings by individuals can be very uncomfortable for nonnative researchers. . . . They may think their research questions are the most important [and they don't understand] why the community doesn't think they are so important. "Epidemiology findings tell us X is high. . . [so for the researchers it is] a big issue, but they don't understand why is it not for the community. There are so many such issues. Often time they [people in the community] are putting out fires. [They] don't have time to

address those issues the researchers think are most important. (PH/COM)

Work with Native American communities to develop sustainable programs sometimes creates a dilemma for researchers. They have to work between the communities which require strict rules to release data and the academia where productivity is measured by publications. The researchers believe that the data and products should go back to the native communities, and that it should be the decision by the native community if the research is to be made public.

6. Discussion

From the interviews with medical doctors who practice and who teach future medical doctors, public health practitioners, and communication professors who teach and do research in health communication and intercultural communication, two things are clear: (1) each field has somewhat different ends, means, and may use different terms for similar concepts; and (2) although there are significant differences in emphasis, the mutuality of concern and relevance is also readily apparent.

There are semantic differences that may conceal differences in meanings across the three fields of study or that suggest distinctions that exist in the naming more than in what is referred to. “Cultural competence” is used in medicine and either “cultural competence” or “cultural humility” is used in public health. Those words are comparable to “cultural sensitivity” or the broader term, “empathy,” as used in intercultural communication scholars in the same contexts.

All practitioners expressed the importance of communication from their own professional perspective. It is notable that some practitioners have multiple professional backgrounds; in the present study, for example, half of the public health practitioners have degrees in communication. The influence of communication

within the medical field is likely to increase with a recent requirement that medical students also complete a certificate course in public health because of the recognition that many health issues are not unique to individuals, but rather are issues for the larger community.

The medical school curriculum gives attention to communication in the core curriculum. Interaction with role-players acting as "standard patients" compels medical students to develop their communication skills but medical students learn communication more from practical trainings. In the beginning of their medical school training, the students have the chance to work with homeless people and observe doctors and patients in clinical settings. When students actually do practical training in a clinic, they are sent to places far from where they grew up, even if it is within the same state. Faculty who have rich experience in working with people from various backgrounds make efforts to give students opportunities to learn through experience about culture and communication.

In medicine, "communication" has a narrower meaning than in the academic discipline, communication. *The Kalamazoo II Report* (Duffy, et al., 2004) distinguished "communication," which included obtaining a medical history, explaining a diagnosis, from "interpersonal skills" which are relational and process oriented. Communication professionals include both as "communication."

In the medical field, "intercultural communication" is not a viable concept. Instead, a comparable term, "cultural competence," is used. A medical school professor who designed the curriculum explained that they use words such as "communication competency" and "intercultural competency" as measurable behaviors through which progress toward specific goals can be identified. Medical school culture values the ability to observe and measure behaviors in the context of desired outcomes. Thus in the medical school more than in the other areas

"communication" is described in terms of checklists and quantification. In contrast, communication professors regard communication as centered on "relationships" which cannot be measured so clearly. Where the medical school focus is on the doctor-patient interaction the health communication specialist will also be concerned about the doctor's self-awareness.

In addition to the importance of cultural competence, cultural humility is also important.

> Cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations. (Tervalon & Murray-Garcia, 1998, 123)

In this sense a notion of cultural humility is closer to cultural awareness and sensitivity in the field of intercultural communication which are the basics in interacting with people from different cultural background.

As the literature and the present study indicate, intercultural training in the medical school tends to focus more on "others" (Van Wieringen, J.C.M. et al., 2001) with little acknowledgment that doctors and other medical practitioners are affected by their own cultural backgrounds that influence their perceptions and actions. Some of the PH practitioners/researchers are aware of their own professional cultural background and how they can affect the people with whom they interact. Those people who have been in the field recognize the importance through their own experiences, and their practical experience could inform those who are just entering the field.

Communication professors describe the trends that give less attention to

intercultural issues and more attention to interpersonal and organizational communication, and mass media. Academic territorial issues and current trends in publication were cited as reasons.

Research projects in public health with a CBPR basis require interaction that fosters collaboration with the communities they serve. Consequently, PH practitioners need to be sensitive to their own assumptions and behavior as they seek to develop strong and sustainable relationships. How to approach a community, how to get information, how to share the results, and how they can actually develop an effective health program all affect their ability to develop crucial relationships. All practitioners emphasized the importance of developing relationships and learning about the communities they work with. Practitioners commented on the lack of communication and intercultural communication components in their training.

In physician-patient interaction an understanding of cultural specific information relevant to health beliefs and practices is considered central to cultural competence. However, medical practitioners are also concerned that too much dependency on cultural specific knowledge may lead to stereotyping.

Practitioners in public health and communication indicated that they do not know enough about other cultures or the influences from the practitioners' own cultural backgrounds. The emphasis of "listening" and "respect" in the interview comments from practitioners in all three areas indicates the importance of developing relationships and learning from each other as partners. Studies indicate that both patients and health care providers recognize that empathy is a very important component of intercultural competence (Gibson & Zhong, 2005). A medical doctor who also has a degree in Public Health noted that in this diverse society in the 21st century, guiding medical students to identify and examine their own patterns of unintentional and intentional racism, classism, and homophobia is essential

(Tervalon & Murray-Garcia, 1998). A critical perspective, currently emphasized in intercultural communication curricula, may exert an influence on health practitioners as they interact with individual patients and their communities.

The interviews also reveal a hierarchy based on the degree to which a subject is "science-" or "data- based". Metaphors of "hard" (evidence-based/quantitative studies) are contrasted with "soft," theoretical/qualitative, research. Of the three fields considered in the present study, the medical school is the most science-oriented, communication the least science-based, and public health, which shares characteristics of each, is somewhere in between. Theory, which may be a strength of the communication field, is not central to medical training; rather, direct experience and empirical data are valued. Public health practitioners also indicated that theory is not a significant part of the PH curriculum, but some PH participants who had studied communication said they would like to see more of the communication theory included in their field. Those who come from the communication field are also aware that it is difficult to demonstrate empirically that that greater attention to intercultural communication will lead to more effective outcomes.

7. Conclusion

The stream of attention to communication for better health is fed by three tributaries: medical practice, public health campaigns, and within the field of communication, intercultural communication and health communication. Less notable than the differences in terms used for common interests, or territorial claims that defend disciplinary borders is the mutual appreciation of the value of each of these allied fields, but with a recognized hierarchy of demonstrable effectiveness favoring a "hard-data" and "science base." There is also an implicit time dimension: medical practitioners must deal with short-term concerns, often emergencies. Public

health campaigns have a longer time-frame, working to change behavior today that will have long terms effects. The field of communication offers theoretical, often culture-general and "cultural self-awareness," perspectives, along with specific intercultural health communication research that may be seen as adjunct to other health fields as they are not part of the medical school culture.

"Health" is the mutual concern among the three areas, but "communication" is central to the process in each, whether defined more narrowly by the medical practitioners (and medical school students) or broadly by those in the field of public health. Both of these fields can benefit from the field of intercultural communication, but that will depend on more effective interdisciplinary communication across these fields.

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Appendix I: Interview Guide

1. What was your motivation to come into this field? /What made you interested in this field?
2. How much cultural knowledge is necessary in your work?
3. How do you regard the relative importance of culture-specific and culture-general knowledge?
4. In your work, do you need to involve people from the community – if so, what are their roles? (Can you give some examples?)
5. What is the importance of intercultural communication? (intercultural communication – especially ethnicity, but also regional, socio-economic, gender, sexual orientation, religious background) Can you give a specific example?
6. Is there anything you know now that you wish you had known when you began this work? (Examples.) (What would you advise others?)
7. What are things that were not taught in the classroom, but which you learned through experience? (Are there ways in which classes can facilitate this learning?)
8. What would you want to tell people from PH about communication, and vice versa?
9. What would you like to achieve in your profession?
10. Please describe any rewarding experience?
11. Please describe any challenging experience?
12. If you could design an ideal curriculum for people who will be working in your field, what kind of courses you want to include?

Appendix II: List of Interviewees

		Highest Degree/ Other Degree	Primary work	Primary Area of teaching	Classes on Intercultural Communication
1	MED 1	ME.D. /PH certificate	doctor/teacher	Medical School	NA
2	MED 2	ME.D.	doctor/teacher	Medical School	NA
3	MED 3	ME.D.	doctor/teacher	Medical School	NA
4	MED 4	ME.D.	doctor/teacher	Medical School	NA
5	MED 5	Nursing	practitioner/ teacher	Medical School	Graduate Level
6	MED 6	COM MA	training/curriculum	Medical School	Graduate Level
7	PH 1	PHD	researcher/teacher	Public Health	NA
8	PH 2	PHD/Nursing	researcher/teacher	Public Health	NA
9	PH 3	PHD/COM MA	consultant/teacher	Public Health	Graduate Level
10	PH 4	PH MA/COM MA	researcher/teacher	Public Health	Graduate Level
11	PH 5	Psychology Ph.D.	researcher/teacher	Public Health	NA
12	PH 6	Law Ph.D.	researcher/teacher	Public Health	NA
13	PH 7	Ed.D.	consultant	Public Health/ Education	Graduate Level
14	PH/COM	COM Ph.D./PH MA	researcher/teacher	Public Health/ Education	Graduate Level
15	PH/COM	COM Ph.D./PH MA	researcher/teacher	Communication	Graduate Level
16	COM/PH	COM Ph.D./PH MA	researcher/teacher	Communication	Graduate Level
17	COM 1	COM Ph.D.	researcher/teacher	Communication/ Medical School	Graduate Level
18	COM 2	COM Ph.D.	researcher/teacher	Communication/ Medical School	Graduate Level
19	COM 3	COM ABD	consultant/teacher	Communication	Graduate Level

MED: Medical School
PH: Public Health
COM: Communication
PHD: Doctorate degree in Public Health
PH MA: Master's degree in Public Health
COM Ph.D.: Doctorate degree in Communication
COM ABD: Doctorate student in Communication
COM MA: Master's degree in Communication