Language-specific skills in intercultural healthcare communication: Comparing perceived preparedness and skills in nurses' first and second languages

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ABSTRACT

Background: Interactions between people from different cultures are becoming increasingly commonplace in contemporary healthcare settings. To date, most research evaluating cross-cultural preparedness has assumed that medical professionals are speaking their first language (L1). However, as healthcare workers are increasingly mobile and patient populations are increasingly diverse, more and more interactions are likely to occur in a professional's non-native language (L2).
Objectives: This study assessed and compared nurses' perceived cross-cultural preparedness and skillfulness in their interactions with patients from other cultures when speaking both their L1 and L2. The goal of this project was to inform the creation of a communication skills training program.
Design: Nurses reported their perceived cross-cultural preparedness and skillfulness (scales adapted from Park et al., 2009) in their L1 and L2 via an online questionnaire.
Settings: This questionnaire was distributed among nurses working in Vienna, Austria, through the Vienna Hospital Association (VHA).
Participants: Nurses and nurses-in-training working in VHA hospitals participated. Most participants who provided demographic information were currently nurses (*n* = 179) with an average of 16.88 years (SD = 11.50) of professional experience (range: 0–40); *n* = 40 were nurses-in-training with an average of 2.13 years (SD = 0.88) of experience (range: 1–5).
Methods: Descriptive statistics for each cross-cultural preparedness and skillfulness (in each language) are reported; comparisons between L1 and L2 responses were also conducted. Multiple regression analyses were used to identify predictors of preparedness and L1/L2 skillfulness.
Results: Nurses reported feeling significantly less confident in their skills when working in an L2, across a range of culture-related issues. Having had previous communication skills training predicted (better) self-reported L2 skillfulness, although it did not predict L1 skillfulness.
Conclusions: These results indicate that there is a language-specific component to cross-cultural skillfulness. Thus, there is a need for language-specific skills training to address L2 skill deficits.

In healthcare contexts, interactions between people from different cultures are becoming increasingly commonplace. This increase in intercultural contact can be traced to two primary sources. First, increased migration and movement of people in general, worldwide, is resulting in more diverse and multicultural patient populations (e.g., Stilwell et al., 2004). Second, and related, increased mobility of medical professionals—sometimes promoted by recruitment of foreign workers—is resulting in more diverse and multicultural workforces in clinics and hospitals (e.g., Jinks et al., 2000).

This is particularly the case for medical professionals, such as nurses, in the European Union. Western Europe is currently suffering from a shortage of qualified healthcare professionals in terms of both doctors and nursing staff (Eurostat, 2015). As a result, many countries welcome foreign medical professionals—sometimes actively recruiting them—from both within and outside the European Union (Stilwell et al., 2004). In an EU context free movement has been facilitated by Directive 2005/36/EC on the recognition of professional qualifications, which came into effect in October 2007. As a result, medical teams increasingly consist of staff with diverse ethnic, cultural and linguistic backgrounds (Stilwell et al., 2004; Jinks et al., 2000). The recent influx

of migrant groups to the EU has further increased the cultural and linguistic heterogeneity of this patient population.

As cultural and linguistic diversity in healthcare contexts increases (see Schouten and Meeuwesen, 2006 for a review of the literature), so does the frequency of intercultural interactions. All of these factors contribute to a growing need for medical professionals to have strong intercultural communication skills, ideally in more than one language. Communication about medical and health-related issues has direct implications for patient health outcomes (e.g., Hewett et al., 2009) and can literally be a matter of life and death (Meuter et al., 2015). Risks to patients increase when medical professionals lack the needed skills to communicate effectively with patients. As Meuter et al. (2015) observed, "When clinicians lack the linguistic and cultural skills needed and interpreters are not available, patients may have to rely on medically inexperienced, bilingual relatives or non-medical staff" (Meuter et al., 2015, p. 2). With this come increased risks of miscommunication or communication errors.

To address these risks, it is important for healthcare personnel to be trained in cross-cultural competence (CCC).[1] CCC is defined as "the ability to provide quality care to patients from different socio-cultural backgrounds" (Bardet et al., 2012, p. 107). Generally, teaching and learning of CCC addresses three domains: knowledge, skills, and attitudes. According to Bardet et al. (2012), "Cardinal aspects [of CCC] include the ability to manage language barriers, communication styles, mistrust and prejudice, family dynamics, customs and spirituality, and sexual and gender issues. CCC depends also on demonstrating empathy, curiosity, and respect" (p. 107).

The importance of CCC, and cross-cultural communication skills more broadly, is generally recognized by the professional community: *interpersonal communication* and *multicultural nursing*, for instance, are defined as indispensable competencies for patient-centered care (AACN, 2008, p. 22[2]; CCNE Accreditation, 2016; EFN, 2015) as are the competencies to give advice independently, instruct and support persons needing care and comprehensively communicate professionally (Directive 2013/55/EU of the European Parliament and of the Council). However, medical professionals do not always receive adequate education and training in these areas (see e.g., Bardet et al., 2012; Park et al., 2009). Casillas et al. (2015) specifically cite lack of experience and inadequate training as factors contributing to medical providers' lack of cross-cultural preparedness.

To date, most research evaluating medical professionals' cross-cultural preparedness has assumed that medical professionals are speaking their first language (L1). However, as healthcare workers are increasingly mobile and patient populations are increasingly diverse, more and more interactions are likely to occur in a medical professionals' non-native (e.g., second) language (L2) (e.g., Gasiorek and Van de Poel, 2012; see also Van de Poel and Brunfaut, 2010; Van de Poel et al., 2013). Although individuals' *awareness* of cross-cultural issues, as well as content *knowledge* about other cultures (e.g., specifics of cultural norms, practices, preferences), should be preserved when they move between languages, their corresponding communication *skills* may not be. This is because there is a language-specific component to such skills: being able to communicate in a cross-culturally competent way requires not only awareness that culture-related issues need attention, but also being able to actually formulate statements and responses that effectively address these issues. Thus, cross-cultural preparedness requires

not just *knowing what* needs to be done, but also *knowing how* to carry it out in conversation (e.g., how to negotiate a treatment plan, determine how a patient wants to be addressed, take a social history; Park et al., 2009). If nurses' competence and/or skills in a specific language (e.g., an L2) are not sufficiently well-developed, this *knowing how* component can be compromised. This, in turn, has direct consequences for nurses' ability to care for patients effectively.

To examine the relative importance of language in cross-cultural preparedness, the present study assessed and compared nurses' perceived preparedness and skillfulness in their interactions with patients from other cultures when speaking both their first language and another, second language. Specifically, the research questions guiding the study were:

RQ1: Do nurses report different levels of perceived cross-cultural skillfulness in their first language (L1) and another, second language (L2)?

RQ2: Do (a) professional status (i.e., as a nurse vs. nurse in training), (b) previous communication skills training, and (c) previous language specific-skills training predict nurses' self-reported general cross-cultural preparedness, or cross-cultural skillfulness in either their L1 or L2?

RQ3: What skills do nurses who work in two or more languages report that they would like to learn, if they had the opportunity to receive professional training in another language?

The ultimate goal of this project was to inform the creation of a defensible training program (see Weideman, 2017) addressing cross-cultural medical communication. The information gathered in this study was intended to identify nurses' needs and wants with respect to such a program.

1. Method

1.1. Procedure

The data reported here were gathered via an online questionnaire. This questionnaire was distributed among nurses working in Vienna, Austria, through the Vienna Hospital Association (VHA). The VHA includes all hospitals and geriatric centers of the city of Vienna as well as six training facilities for general health care and nursing care. This consortium is one of the largest hospital operators in Europe and is Austria's largest provider of education in healthcare. The deputy director general of the VHA first approved the questionnaire for distribution; then, the VHA's director for education and training distributed a link to the online survey to all the consortium's head nurses, with a note that participation was strongly encouraged. The head nurses then distributed the survey link to their nursing staff, who completed the questionnaire voluntarily. Any nurse who received the questionnaire (which was sent by their head nurse to their professional email address) was considered eligible to participate. Not all participants who began the questionnaire (N = 330) completed all items; results below are reported from those who answered a given item or set of items (as indicated).

The focal measures of the questionnaire were questions drawn and adapted from Park et al.'s (2009) Cross-cultural Preparedness and Skillfulness Scale (see also Weissman et al., 2005). Although this scale was originally designed for medical doctors, it has also been used with nurses (Casillas et al., 2015; Flood and Commendador, 2016). All questionnaire items were translated to German, and subsequently back-translated to ensure the fidelity of the translation. All participants completed the questionnaire in German. (The results reported here use the original English item wordings for English-speaking readership; a copy of the German-language survey is available from the authors.)

In the questionnaire, participants first evaluated their general cross-cultural preparedness (six questions) as well as their ability to work

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[1] For a critical discussion of the difference between intercultural, transcultural, cross-cultural communication and multiculturalism, see Van de Poel et al. (2013). In particular the terms 'human care' and 'transcultural nursing' have been well-established since the work of the progressive nurse Madeleine Leininger in the middle of last century to refer to professional nursing interacting with the concept of culture. Comprehensive definitions, theoretical models and references can be found on the websites of the Transcultural Nursing Society (http://www.tcns.org/) and the European Transcultural Nursing Association (http://europeantransculturalnurses.eu/).

[2] Essential VI: Communication and collaboration among healthcare professionals are critical to delivering high quality and safe patient care (ACCN, 2008, p. 3).