

# AN EDUCATIONAL INTERVENTION TO IMPROVE CROSS-CULTURAL, CONFLICT RESOLUTION SKILLS IN THAI MEDICAL TOURISM

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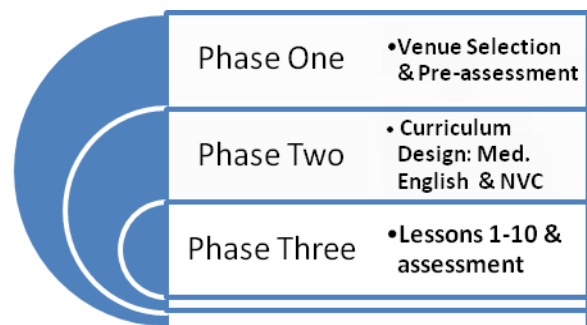
**Abstract:** While low English language proficiencies create significant barriers to communication, cultural dimensions in Thai medical tourism make cross-cultural conflict resolution (CCCR) even more problematic. Previous studies and interventions in English Language Teaching (ELT), English for Specific Purposes (ESP) and Medical English Education (MEE) have focused on English language skills and cross-cultural knowledge. Significant improvements in conflict resolution skills have not been noted. This intervention integrates medical English and counseling skills. In each lesson, the instructor uses a skills scaffolding approach, and sequences learning objectives along Bloom’s revised taxonomy of learning skills (BRT). The conflict resolution instruction and practice are based on Rosenberg’s Non-violent Communication (NVC) protocols (2003). Participants learn and apply counseling skills via readings, role-plays, games and discussions. Conflict scenarios in medical tourism provide the primary content. The first third of the thirty, weekly, medical English and counseling workshops at Piyavate Hospital, Bangkok, and the first three study phases of six, pre-assessment, curriculum development and progress assessments of workshops one through ten have been completed. The assessment results reported here convey participants’ conflict and cross-cultural communication values in three areas: uncertainty avoidance, conflict avoidance, and patient assertiveness. Both pre-assessment and progress assessment include completion of an eighteen- item Likert scale survey derived from Hofstede (1980), and Chareonrook (2000). This integrative approach via combined medical English and conflict-resolution training suggests ways that counseling may be integrated into Thai, medical English curriculum.

**Keywords:** Cross-cultural Conflict Resolution, Bloom’s Revised Taxonomy of Learning Skills, Non-Violent Communication

## Introduction

Cross-cultural communication between Thai medical staff and foreign patients is problematic and often reported in conjunction with patient dissatisfaction and malpractice suits (Armbrecht, 2008). Thai medical personnel struggle with their patients’ varied styles of communication and cultural/medical backgrounds and beliefs. Research reveals that proficiency in English, the ‘lingua Franca’ of Thai medicine has not significantly mended cross-cultural,

communication barriers. The unique relationships of medical staff and patients and the challenges of communication across cultures warrant intervention. This educational intervention and longitudinal study provide medical professionals an integrated curriculum in medical English and counseling while tracking learning outcomes. In weekly workshops at Piyavate Hospital, participants are introduced via skills scaffolding to learning objectives they then explore with a full range of learning activities drawn from Bloom’s revised taxonomy of learning skills (BRT). Pre-surveys, progress surveys, and post- surveys and questionnaires as well as audio recordings of sessions are tracking participants’ performance from April 2010 to January 2011. Medical English and issues in medical tourism provide the workshop contents while Non-violent Communication (NVC) protocols that have bridged cultural differences in other settings provide a communication process that engages medical staff with foreign patients and helps them resolve cross-cultural conflicts (2003). During the workshops, participants apply medical English and counseling skills to a variety of cross-cultural, conflict situations via role-plays, discussions, games and readings. Each session ends with time devoted to discussing issues and conflicts that participants encounter day to day. In this progress report, the first third of the thirty, weekly, medical English and counseling workshops at Piyavate Hospital, Bangkok, and the first, three study phases of six, pre-assessment, curriculum development and progress assessments of workshops one through ten are reported (Figure 1). Results describe changes in three of the participants’ CCCR avoidance factors: patient assertiveness, uncertainty avoidance and conflict avoidance.



**Figure 1: Scope of This Progress Report**

## Objectives

The objectives of this research study are: 1) To develop and test a medical English curriculum which includes counseling and conflict resolution training; and 2) to practice, and to study and analyze the participants’ attitudes toward and skills in cross-cultural conflict resolution.

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## Literature Review

According to the Kasikorn Research Centre, between one and two million, foreign medical travelers visit Thailand each year, generating revenue of 30 to 40 billion baht (Fernquest, 2005). Though ranked among the best worldwide in medical training, technology, and affordability, Thai hospitals and the Thai medical tourism industry struggle with communicating with their foreign patients.

Armbrrecht reports that medical staff and foreign patient communication errors and conflicts “sometimes hav[ing] tragic consequences” are the most frequently mentioned causal factors in malpractice suits (2008). The need for cross-cultural conflict resolution skills in the Thai medical tourism industry has been the focus of numerous studies over many decades. Government and non-governmental agencies, accrediting bodies, ELT, ESP and MEE educators, researchers and numerous medical agencies, hospitals and staff have investigated and defined the problems. Cross-cultural barriers to communication and models for explaining communication process across cultures, including context communication styles (Gudykunst et al., 1996) and the importance of conversational constraints (Kim et al., 1996) have helped identify the issues, problems medical staff, and foreign patients face.

This study draws from such research into cultural dimensions and variables that distinguish people who are Thai from non-Thai culturally. Chareonrook (2000), for example, identifies factors important to consider in Thai, cross-cultural communications in medical tourism. Her research defines one of three factors related to communication between Thai medical staff and foreign patients that this research tracks: (1) foreign patient assertiveness. The remaining factors, as defined and studied by Hofstede and others are: (2) uncertainty avoidance; and (3) conflict avoidance (1980).

Problems related to cross-cultural conflicts, though well documented, have rarely resulted in interventions, and those interventions which have been studied have met with limited success (Chareonrook). Reliance on cross-cultural knowledge alone has not been shown to help Thai medical staff when it comes to addressing day-to-day communications and cross-cultural conflicts with foreign patients.

The intervention’s organizational plan, depicted in Figure 2, differs in several ways from previous interventions in Thai medical settings. It provides: 1) an integrated medical English curriculum via skills scaffolding techniques to medical professionals at their facility; 2) weekly lessons in counseling skills and application of skills for the duration of a ten-month program; and 3) reinforced language and NVC counseling, learning objectives through a complete curricular application of Bloom’s revised learning-skills taxonomy (BRT) to cross-cultural conflict resolution (CCCR) (Forehand, 2005). The scaffolding technique provides a framework for introducing new material while Bloom’s

revised taxonomy of learning skills (BRT) help learners integrate and apply the new information and communication techniques through the graduated levels of BRT learning skills.



**Figure 2: Proposed Model for CCCR Intervention**

## Research Methodology

Development of medical English and counseling curriculum and a study of its effects on Thai medical staff in the medical tourism industry has been the product of years of research, the teaching of medical English, teaching and designing English as a foreign language (EFL) curriculum and becoming fluent in NVC counseling as an NVC facilitator in three previous medical settings. That being said, the most salient research and methodology underpinnings of the first three phases of this study follow:

Phase 1 of the study, January to March 2010 began with a search for an adequate venue for the workshops and study. Criteria for the choice were (1) breadth of medical care, preferring a non-specialized medical tourism ward; (2) medical staff with intermediate or higher English language skills; (3) a sufficient number of daily encounters with foreign, English speaking patients; and (4) A hospital mission that includes medical tourism.

Both government and private hospitals were engaged and three hospitals, Mahidol, Sirirat, and Piyavate were chosen for the assessment phase. These hospitals showed high interest in the workshops and study. After three, pilot workshops with doctors and nurses in each, Piyavate’s general medicine ward was selected for the study for its superior ranking per the stated criteria. (1) Its general, “check-up” ward includes a wide range of medical staff and services including physical exams, lab-work, radiology, gynecology, obstetrics, optometry, ophthalmology, the heart center, pediatrics and a new dentistry unit. Though patients with special needs or very serious conditions may be referred from the general ward to more specialized wards in the hospital, foreign, English speaking patients meet this ward’s staff first, “on the front lines” of the medical tourism industry. (2) All medical staff in this ward must minimally have an intermediate level of proficiency in English as determined by their TOEIC test scores. All doctors must have advanced skills in English. (3) Hospital statistics show an average of 5 to 35 foreign, English speaking patients daily, a number that Mahidol and Sirirat wards did not approach. (4) The mission statement

of Piyavate includes as a stated purpose to “encourage the trend of medical tourism to Thailand” (2004). Figure 3 shows a Piyavate nurse and one of her English-speaking patients. Cultural diversity among English speaking patients is a desirable trait for CCCR research.



**Figure 3: The Piyavate General Medicine Ward**

In Phase 2, the curriculum and design phase, three design objectives were selected: (1) to create a week to week pattern of instruction for the medical English and counseling lessons integrating four English language skills including reading and writing but emphasizing listening and speaking communication skills particularly suited to communication with foreign patients. Participants would ideally be able to contextualize new information and communication strategies in a predictable and efficient way. Scaffolding instruction was therefore researched and then included in the instructional design.

Scaffolding instruction, originating from Lev Vygotsky’s socio-cultural theory and his concept of the zone of proximal development (ZPD) creates a framed pattern participants benefit from through individualized instruction (Jaramillo, 1996). For example, the zone of proximal development, defined as the distance between what learners can do themselves and the next learning that they can be helped to achieve with competent assistance” (Raymond, 2000), was determined initially by Phase 1 assessment. ZPD of learners was determined by pre-assessment writing samples and interviews with the fifteen workshop participants. The ZPD base line for learners was adjusted per their week-to-week performance and instructor/learner interactions. The key to the scaffolding teaching strategy is to provide individualized support based on the learner is ZPD (Chang, Sung, & Chen, 2002), so close attention was paid to each staff members’ language, medical English and counseling skills.

Scaffolding instruction in this setting provides a pattern of health-care and counseling related words and phrases beyond the participants’ expertise. The instructor models the words and phrases and appropriate grammatical structures for manipulating them in conjunction with power-point diagrams, photos, charts handouts, work

sheets etc Weekly, scaffolding pattern supports and facilitates each learner’s development, building on prior knowledge and helping to internalize new information. The activities provided in the scaffolding instruction were, as suggested, “just beyond the level of what the participants could do [the previous week]” (Olson & Pratt, 2000). The instructor provides the scaffolds so that the learner can accomplish (with assistance) the tasks that he or she could otherwise not complete, thus helping the learner through the ZPD. Several studies have demonstrated a marked efficiency in a scaffolding approach in instruction that keeps the learners “on the edge” of what they learned and are yet to learn (Bransford, Brown, & Cocking, 2000).

In Phases 2 and 3, Bloom’s revised taxonomy of learning skills (BRT) reinforced learning objectives. New material introduced using the scaffolding process was then followed up with BRT. BRT provides a framework for participants to fully process the information and apply it to CCCR content. Games, team competitions, role-plays and discussions all centered on medical tourism issues and cross-cultural conflict content were incorporated into the design. Weekly, NVC counseling learning objectives were explored along BRT utilizing the four NVC counseling protocols: making observations, addressing feelings, connecting to needs, and making requests. These protocols applied to CCCR content and day-to-day discussions of encounters with foreign patients and issues in medical tourism engaged all six BRT skills: remembering, understanding, applying, analyzing, evaluating, and creating (Forehand, 2005). Lexical-grammatical learning objectives were cast in terms of these four protocols and provided a counseling oriented “narrative flow” to the workshops. Participants have come to share a common purpose for acquiring English language objectives because they have seen how they relate directly to specific counseling skills that help them communicate with foreign patients.

After the completion of the ten, Phase 3 workshops, a progress report survey was administered. In this ten-month, thirty-lesson, six-phase longitudinal study, CCCR learning outcomes are studied and assessed in several ways. Over the entire 6 Phases of the study, learner language and cultural and linguistic performance via written and recorded English samples are studied using systemic functional grammar (SFG) (Halliday, 1994). Progress reports like this one marking the conclusion of the first instructional phase, focus on participant attitudes and behaviors related to CCCR avoidance.

A Likert scale survey and a split value description, basic, but reliable tools for describing changes in participant attitudes and behaviors toward three CCCR avoidance factors, patient assertiveness, conflict avoidance and uncertainty avoidance were selected. Three stages of instrument development were employed. First, the researcher is testing tools, derived from Hofstede (1980) and Chareonrook (2000). CCCR research and criteria were applied via an eighteen item, Likert scale, survey administered first as a pre-assessment and in Phase 3 as a

progress reporting tool. CCCR avoidance factors were studied and items indicating specific attitudes and behaviors associated with CCCR avoidance were written. Additionally, survey items were re-ordered after use in pre-assessment and before use in progress report assessment administration to reduce test-re-test unreliability. Second, the instruments were submitted to and approved by the researcher's doctoral-research director, Dr. Joseph Foley. Third, for measuring Phase 1 impact on CCCR factors, the pre-workshop, Likert scale questionnaires and the Phase 1 Likert scale questionnaires, a variety of data analysis and reliability methods were carefully considered. Due to the low number of participants and the longitudinal nature of the study, a simple, descriptive model was chosen. Pre-assessment results for assertiveness avoidance are depicted in Table 1.

from 59.9 to 26.6, from 73.3 to 73.3, from 86.6 to 53.3, and from 59.9 to 53.3. Table 2 (see in next page) describes the decrease in avoidance item by item. Item five showed the largest decrease in avoidance from 86.6 to 53.3 and may reflect participants' increasing confidence in their English communication skills with patients. Figure 4 (see in next page) shows how all eighteen avoidance items tallied show a decrease in avoidance.

#### 2) Conflict Avoidance

The pre-workshop and progress surveys showed the most significant decrease in conflict avoidance from and over-all decrease of 22.25 percent. NVC counseling encourages learners to welcome conflict and provides concrete steps for understanding conflict scenarios and how conflicts may be addressed and learned from though this preliminary progress report gives a general description

**Table 1: Highlighted CCCR Avoidance Tendencies, Piyavate, Pre-Survey**

CCCR: Patient Assertiveness Pre-Assessment Items: Piyavate Hospital, Bangkok March, 2010 Total Respondents: 15	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Split Half for Avoidance
I ask my supervisor for help with assertive foreign patients.	26.6% (4)	40% (6)	26.6% (4)	6.6 % (1)	0% (0)	66.6%
I feel uncomfortable when foreign patients speak in a loud voice.	20% (3)	33.3% (5)	26.6% (4)	13.3% (2)	6.6% (1)	53.3%
I feel surprised when foreign patients make many challenging requests.	26.6% (4)	33.3% (5)	20% (3)	13.3% (2)	6.6% (1)	59.9%
I feel that foreign patients should try to respect and follow instructions of Thai medical staff	33.3% (5)	40% (6)	20% (3)	6.6% (1)	0% (0)	73.3%
I do not have enough confidence in my English language skills when foreign patients ask me questions about their care.	46.6% (7)	40% (6)	13.3% (2)	0% (0)	0% (0)	86.6%
I am more comfortable with gentler foreign patients.	26.6% (4)	33.3% (5)	26.6% (4)	13.3% (2)	0% (0)	59.9%

#### Conclusion

The split-half descriptions of results from the medical English and counseling intervention via the pre-workshop and progress surveys follow. The progress survey, administered after ten weeks of medical English and counseling workshops records a significant decrease in three CCCR avoidance factors: patient assertiveness, conflict avoidance, uncertainty avoidance.

##### 1) Patient Assertiveness

According to the pre-workshop surveys, participants avoided assertive patients more than half the time in the situations depicted in the 6 items. The progress results showed a lessening of avoidance. A split-half description of the responses in which the neutral answers are not included and the sum of the two CCCR avoidance answers, "agree and strongly agree" choices are grouped to describe avoidance tendencies. The following set of results for six, assertiveness avoidance items describe the lessening of avoidance from 66.6 to 46.6, from 53.3 to 40,

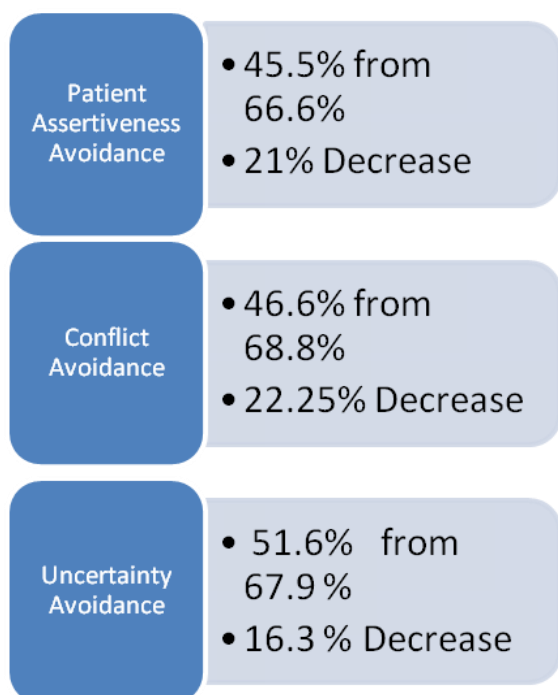
of changes in avoidance tendencies, this factor was encouraging. The following set of results for five, conflict avoidance items describe the lessening of avoidance from 59.9 to 33.3, from 80 percent to 46.6, from 86.6 to 59.9, from 73.3 to 60, and from 60 to 26.6. The final item, "Differences of opinion are usually not worth worrying about so I try to avoid them" remained at the same percentage of avoidance, 53.3 percent for both pre and progress surveys, though fewer respondents chose "strongly agree" and more chose "agree" on progress surveys.

##### 3) Uncertainty Avoidance

The uncertainty avoidance factor compared to the other two CCCR avoidance factors decreased the least. Uncertainty avoidance fell 16.3 percent. The following set of results for five, uncertainty avoidance items describe the decreased avoidance from 59.9 to 46.6, from 53.3 percent to 33.3, from 80 to 60, from 80 to 53.3, and from 66.6 to 46.6. One item did not change in split-half description.

**Table 2: Highlighted CCCR Avoidance Tendencies, Piyavate, Progress Survey**

CCCR: Patient Assertiveness Progress Assessment Items: Piyavate Hospital, Bangkok August 26, 2010 Total Respondents: 15	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Split half for Avoidance
I ask my supervisor for help with assertive foreign patients.	20% (3)	26.6% (4)	40 % (6)	13.3 % (2)	0% (0)	46.6% from 66.6%
I feel uncomfortable when foreign patients speak in a loud voice.	13.3% (2)	26.6% (4)	26.6% (4)	33.3% (5)	0% (0)	40% from 53.3%
I feel surprised when foreign patients make many challenging requests.	0% (0)	26.6 (4)	40% (6)	33.3% (5)	0% (0)	26.6% from 59.9%
I feel that foreign patients should try to respect and follow instructions of Thai medical staff	13.3% (2)	40% (6)	26.6% (4)	20% (3)	0% (0)	53.3 from 73.3%
I do not have enough confidence in my English language skills when foreign patients ask me questions about their care.	6.6% (1)	46.6 (7)	33.3% (5)	13.3% (2)	0% (0)	53.3% from 86.6%
I am more comfortable with gentler foreign patients.	20% (3)	33.3% (5)	26.6% (4)	20% (3)	0% (0)	53.3 % from 59.9%



**Figure 4: Total Changes in Three, CCCR Avoidance Tendencies over the Eighteen-Item, Pre-workshop and Progress Surveys**

### Recommendations

By integrating the NVC counseling protocols into medical English instruction, a new kind of intervention into CCCR avoidance in Thai medical tourism was initiated. Scaffolding and BRT lesson designs have also been incorporated. This progress assessment which focused on three CCCR avoidance factors will be followed by three more in which the researcher will apply this descriptive CCCR avoidance tool and other assessment and measurement tools to gauge changes in the workshop participants' language proficiencies, attitudes, behaviors and performance in conflict resolution contexts. For example, the researcher proposes an application of a systemic functional grammar (SFG) analysis of written and recorded language samples collected before and during the workshops. Language markers that relate to CCCR avoidance factors should be isolated and studied.

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