Intercultural Communicative Competence Training Programme_Module 1
Exercises to Improve Intercultural Communication Skills

EXERCISE 15 – An illiterate woman

I was admitted to a hospital after suffering from a high fever for several weeks and not receiving any substantial support from my GP. The hospital was full, but still they found a bed for me. It was Wednesday when I was hospitalised. I was placed in a room with two other women, one an older Austrian woman who did not speak much, and one a Turkish woman, approximately 50 years, with a mobile phone which seemed to ring all the time, and was never turned off. Also, it was a very cheap type of phone without the possibility of regulating the volume. The phone rang very loudly.

The Turkish woman would not sit still but was constantly moving around or had family members over for conversations. In the evening 4-6 people were there at once. I could not rest, my body was tired from the fever, and I had to stay clearheaded for several examinations. I had no strength in my body and was upset because she had no respect for me and was acting irresponsibly with her loud voice and her loud phone. She constantly smacked her lips loudly.

The first night I could not sleep. The Turkish woman switched on the lights several times, went to the toilet and left the door open, ate food and grunted and burped the whole night. At 5.00 am she turned on the light in the room and loudly prayed her morning prayer without even caring that two people were still asleep. I could not sleep at all and had a severe headache after that. The situation did not change after several days.

The shock finally occurred when suddenly she stood in front of my bed, while I was trying to sleep, and pulled my arm. She was very close to my face, which was awkward for me. She then showed me the box with her medication, and asked me in Turkish, which one she should be taking right now. I did not understand a word but guessed she was asking me that. Through pointing at the different sections of the box it became obvious that she did not even understand which section said “morning”, which “evening”, indicating when to take which medication. She was illiterate. I pointed to the right section with the medication she should be taking at that hour of day and turned my back on her, signalling that I wanted no contact.

Thirty minutes later she threw herself to the floor and cried and shouted excessively until the

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doctors could calm her down.

I told the doctor that I needed another room, because I would not survive another night with this cruel person, whom I could not explain myself to due to our language barrier, and who had not even a spark of respect on how to share a room in a hospital.

If the doctors had not given me a different room, I would have checked myself out.

Actors in the situation

1. Narrator

Sick woman in her 30s; born in Austria; speaks German, English, French, Russian; has a lot of international experience (lived in different countries); Protestant; highly educated (university degree) from a rather small family;

2. Turkish patient

Sick woman in her 50s; born in Turkey; speaks Turkish; Muslim; no school education, illiterate; married with multiple children;

3. Medical staff

Doctors and nurses coming into the room from time to time, yet not often enough to really experience what is going on in the room.

Both women are in the same situation as they are sick, hospitalised, having to share a multibed hospital room with other women. While the narrator is highly educated, the Turkish patient is illiterate. While the narrator came to the hospital to seek peace and quiet (and is alone most of the time), the Turkish patient is regularly surrounded by many of her family members. What separates them further is that they do not share a common language in which to communicate.

Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

1. Hospital as social space

 Different patients with different needs and potentially colliding ideas of recovery share spaces and are often forced to go about their private business in very close proximity to each other. Thus, hospitals as institutions with heavily diverse users bear a high

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potential for conflict.

 A typical set of conflicts might arise between patients adhering to a collective orientation and patients oriented towards individualism – especially when they have to share rooms, facilities etc. As depicted in this case, the two orientations go along with divergent frames of reference, complicating an interpretation of the other person's actions, leading to attribution errors, insecurities how to act and frustration.

 As a consequence rules on how to act in a hospital should take into account different ideas on recovery, but also safeguard basic needs (such as need for sleep).

 Recommendations:

o Communicating rules and codes of conduct in different languages and with icons: Where are the social rooms located for patients to spend time with their relatives? Where are prayer rooms etc?

o Investing in emergency beds

2. Hospital staff as mediators?

 Staff are usually pressed for time, so that it is often not possible for them to acknowledge what is going on in patients' rooms.

 Creating opportunities for patients to communicate high levels of disturbance; this carries the risk of hospital staff being swamped with complaints.

 Training staff to be aware of conflict.

3. Comprehensive translation and interpreting services in hospitals

 Expansion of in-house interpreters

 Expansion of telephone and video translation services

 Training health care professionals on how to deal with language barriers

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