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# Intercultural communication competence in the healthcare context

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## Abstract

This study examined the intercultural communication competence of medical providers at a healthcare organization, including patient perceptions of the medical provider's ability to communicate with a diverse patient population. Surveys were given to medical providers and patients at a large healthcare organization. One survey asked medical providers to rate their own ability to communicate across cultures, and the other survey instructed patients to rate the intercultural communication competence of their medical providers. Analysis of variance and Pearson correlation coefficients were used to analyze the data from 45 medical providers and 91 patients. The findings demonstrate that empathy, bilingualism, and intercultural experience are related to intercultural communication competence.

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## 1. Introduction

With each passing year the United States is becoming progressively more multicultural. As of 2000 African-Americans composed of 12.7% of the United States population, Hispanics 12.6%, and Asians 3.8% (United States Government

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Census, 2003). According to United States government census estimates, by the year 2020 African-Americans will account for 13.5% of the population, Hispanics 17.8%, and Asians 5.4%. Within this increasingly multicultural society there is a need for competent communication between all cultures in every aspect of our lives. Communication effectiveness is particularly crucial in the area of healthcare during medical provider and patient interactions. Communicative misunderstandings between patient and provider can lead to simple dissatisfaction, misdiagnosis, lack of any medical care, or even death. Ineffective intercultural communication can also lead to stress for health care providers, causing anxiety and job dissatisfaction. [Ulrey and Amason \(2001\)](#) discovered that medical providers unable to communicate effectively across cultures were more anxious on the job. To alleviate these potential problems healthcare providers must become competent intercultural communicators.

Research has investigated the phenomena of healthcare communication and competence in other settings, yet there has been little research concerning characteristics of intercultural communication competence in healthcare settings ([Gardenswartz & Rowe, 1998](#); [Thomas, 1981](#)). Research is inconclusive in demonstrating if appropriateness and effectiveness, which are the key measurements of communication competence, are sufficient variables to determine the intercultural competence of a medical provider in a healthcare setting. There are other potential variables such as empathy, previous intercultural experience, and the ability to speak a second language.

Therefore, there is need for additional research to determine characteristics of medical providers who are competent in intercultural communication. The purpose of this study is to examine the intercultural communication competence of medical providers at a healthcare organization, including patient perceptions of the medical provider's ability to communicate with a diverse patient population.

### *1.1. Intercultural communication competence in healthcare*

Intercultural communication competence (ICCC) developed from previous research that explored interpersonal communication competence (IPCC) ([Bochner & Kelly, 1974](#); [Spitzberg & Cupach, 1984](#)). There has been great difficulty in developing a standard definition for intercultural communication competence ([Hajek & Giles, 2003](#)). Previously referred to as “cross-cultural competence,” “intercultural sensitivity,” or “intercultural effectiveness,” intercultural communication competence is commonly known as “the knowledge, motivation, and skills to interact effectively and appropriately with members of different cultures” ([Wiseman, 2002, p. 208](#)).

Much of the research within the area of intercultural communication competence and healthcare has focused on specific communicative behaviors that are appropriate and effective for individual ethnic groups ([Gold, 1992](#); [Ramakrishna & Weiss, 1992](#); [Scott, 1981](#)). [Thomas \(1981\)](#) discusses how medical providers should remain mindful of African-American Vernacular English when speaking with African-American patients. [Andrews and Boyle \(1995\)](#) list a variety of communicative techniques

appropriate for Mexican patients, while [Lipson and Omidian \(1992\)](#) discussed ways to communicate with Afghan refugees seeking medical treatment.

Recent studies have been more patient focused, stressing the importance of patient-to-provider intercultural communication during medical consultations as opposed to singularly focusing on the abilities of the medical provider ([Street, 2003](#)). [Young and Klinge \(1996\)](#) identified behaviors that prevent Asian-Americans from participating during medical interactions, causing them to have less satisfying experiences during medical visits. [Cooper-Patrick, Gallo, Gonzales, and Vu \(1999\)](#) discussed how members of subcultures within the United States rate their visits with physicians as less participatory leaving them feeling unsatisfied with their medical treatment. Also, [Cegala, McClure, Marinelli and Post \(2000\)](#) examined the effect of communication training on patient's abilities to interact effectively with their doctors. It was discovered that patients who received communication training interacted more effectively with medical providers when compared to patients who did not receive communication training.

### *1.2. Empathy, bilingualism, and intercultural experience as competence*

A number of studies have focused on the specific characteristics of ICCC that are within an individual communicating cross-culturally. These characteristics include the ability to be empathetic, the experience living in a different cultures, and the ability to be speak a second language ([Gudykunst, 1985](#); [Imahori & Lanigan, 1989](#); [Martin & Hammer, 1989](#); [Ruben, 1976](#)). Researchers have viewed the meaning of empathy within the intercultural context as the ability to put oneself in the position of another person, or identify mentally and emotionally with another communicator ([Bennett, 1979](#); [Gudykunst, 1993](#); [Ruben, 1976](#)). [Bennett \(1979\)](#) viewed the latter classification as relating more to sympathy than empathy, defining empathy as the "intellectual and emotional participation in another person's experience" (p. 418). [Bennett](#) would also categorize empathy as an aspect of the "platinum rule," the most important factor of effective intercultural communication, which says an individual should do onto others as that person would do onto him or herself. To examine the role of empathy in intercultural healthcare communication the following hypothesis is posited:

**Hypothesis 1.** There is a positive relationship between empathy and intercultural communication competence among medical providers.

Numerous researchers have identified bilingualism or second language ability as an important aspect of intercultural communication competence ([Hammer, Gudykunst & Wiseman, 1978](#); [Imahori & Lanigan, 1989](#); [Redmond, 2000](#)). [Gudykunst \(1992\)](#) explains, "Even if we cannot speak fluently, our efforts to speak the strangers' language probably will be appreciated and will lead to more effective communication" (p. 237). Other researchers have also concluded that bilingualism has an influence on ICCC through the study of international students studying in the United States ([Redmond & Bunyi, 1993](#); [Schneider & Jordan, 1981](#)). One goal of this

study is to examine the influence of bilingualism on ICCC in the healthcare context therefore hypothesis two is presented.

**Hypothesis 2.** Bilingual medical providers regard themselves as more competent intercultural communicators when compared to monolingual care providers.

Although the research is limited, previous studies have shown that intercultural experience leads to increased knowledge of other cultures causing individuals to communicate more effectively across cultures (Martin, 1987). This increased knowledge has been most prevalent with individuals whose intercultural experience consists of a period of more than three months outside their home country (Abrams, 1979; Adler, 1975; Billingmeier & Forman, 1975; Koester, 1985). Abrams (1979) in a study of 424 college students found those who studied abroad were more motivated to interact with different cultures, an important aspect of intercultural communication competence. Martin (1987) also conducted a study of 175 student sojourners, the majority of whom had been abroad for more than three months. Participants completed a questionnaire that explored four dimensions of intercultural competence: awareness of culture, knowledge of culture, cultural flexibility, and behavioral competencies such as the ability to solve problems and form intercultural relationships. The study found that individuals with three or more months experience abroad had more knowledge of their own culture and other cultures. Currently the affect of intercultural experience on ICCC in the healthcare context is an unexplored area, justifying hypothesis three.

**Hypothesis 3.** Medical providers with intercultural experience regard themselves as more competent in intercultural communication than those without intercultural experience.

### *1.3. Measuring intercultural communication competence*

Research has disputed the most effective method to measure intercultural communication competence. Past research has utilized objective observation, subjective observation, self-report, and receiver-report. Objective reports are studies that require participants to communicate information to an unsuspecting receiver. If the receiver repeats the message accurately, the sender is regarded as competent. The subjective observation requires participants to complete a communicative task on which they are given a score. The self-report asks respondents to assess their own ability to communicate effectively and the receiver-report or other-report requests that receivers assess the skills of the person who has communicated with them (McCroskey & McCroskey, 1988). The final hypotheses is presented to determine the effectiveness of self and receiver reports in measuring ICCC within the healthcare context.

**Hypothesis 4.** There is a difference between medical providers' self-reported ICCC and patient-perceived medical providers' ICCC.

## **2. Method**

There are two purposes for this study: (a) to examine if empathy, intercultural experience, and bilingualism are characteristics of ICCC in the healthcare context, (b) to discover if medical providers' self-perceptions of ICCC are higher than patient reports of intercultural competence. A non-profit health center was chosen as the research location because this organization provides healthcare on a sliding income scale and treats patients with or without insurance. This organization has nine locations in the Western United States and the majority of the patients treated are 200% below the poverty line. For these reasons, it was predicted that the non-profit health centers would care for patients from a variety of ethnic groups. Obtaining data from a diverse patient population was ideal because research in the area of competence has been criticized as ethnocentric, partially due to the mono-cultural makeup of research participants (Deturk, 2001). Hecht, Jackson, and Ribeau (2003) wrote, "Most approaches to competence can be labeled Eurocentric in their focus on European American communication patterns" (p. 91). To test the hypotheses, surveys were given to medical providers and patients at the non-profit health centers and results were statistically analyzed.

### *2.1. Participants*

The participants in this study were 136 medical providers and patients at a large non-profit healthcare organization in the Western United States. Medical providers were defined as any employee who has contact with patients; including doctors, nurses, medical assistants, and administrative assistants. Medical practitioners at six locations of the organization were asked to participate in the study. All patients who received care at the six locations of the medical center had the opportunity to complete a survey regarding ICCC of the medical providers. A total of 91 patients and 45 medical providers completed the surveys. A total of 150 surveys were allotted for patients, while 50 surveys were given to medical providers. This indicates a response rate of 61% for patients and 90% for medical providers.

In the medical provider sample, 43 were female and two were male. The average age was 36, ranging from 18 to 57. The ethnic backgrounds of the providers included 27 Hispanics, 10 Caucasians, five Asians, three providers defined as "other", and one Native American. Among 45 medical providers 37 spoke two or more languages.

In the patient sample, 70 were female and 21 were male. The average age was 28 ranging from 18 to 61. The ethnic backgrounds of the patients included 47 Hispanics, 21 Caucasians, six African Americans, two Native Americans, and 15 patients defined themselves as "other." Among 91 patients 30 spoke two or more languages.

### *2.2. Measures*

Intercultural communication competence among medical providers was measured using 15 items based on the self-perceived communication competence scale (SPCC)

and the personal report of intercultural communication apprehension (PRICA). The SPCC has been proven reliable with a Cronbach's alpha of .92 (McCroskey & McCroskey, 1988). The PRICA has also been proven reliable with a Cronbach's alpha above .90 when completed by native English speakers (Neuliep & McCroskey, 1997). A sample item is "I am very nervous when interacting with patients from a different culture." The items utilized a five point Likert Scale from "strongly disagree" (1) to "strongly agree" (5). Cronbach's alpha was .81 for the 15-item medical provider intercultural communication competence scale. Patient perception of intercultural communication competence was measured by 13 items also based on the SPCC and PRICA. Cronbach's alpha was .88 for the 13-item patient perceptions of intercultural communication competence scale.

A five-item scale with a Cronbach's alpha of .62 measured empathy among medical providers. A sample item is "I can relate well to the feelings of patients from different cultures." While reliability levels above .70 are ideal, researchers have suggested reliability levels of .60 or above are acceptable (Kioussis, 2004; Nunnally, 1978).

To measure bilingualism, patients and providers were asked if they have the ability to speak a language other than English fluently. Those who responded positively were asked to state the language they speak fluently. Some patients who responded to the survey only spoke Spanish and completed the Spanish version of the survey; they were not counted as bilingual.

To determine intercultural experience, medical providers were asked if they had spent three or months outside the United States. While many participants may have visited countries abroad or studied for short periods, past research determined that a much stronger effect was experienced by individuals who traveled abroad for an extended period of time (Martin, 1987).

The survey was translated into Spanish to accommodate patients who may speak English as a second language; the instrument was then back translated into English to examine the reliability of the conversion. It was shown that 88% of the questions corresponded with the intended meaning of the original items in English. The translation was completed by a research assistant who has experience working as a translator for a large metropolitan city in the Western United States. An employee at the healthcare organization completed the re-translation. This individual is responsible for translating company flyers and documents into Spanish for the public.

### 2.3. Procedures

Data were obtained through a survey distributed in medical providers' mailboxes and given to patients at six locations of a large non-profit healthcare organization in the Western United States. The medical staff was asked to complete the survey and then return it to the receptionist at the front desk. After 1 week an email was transmitted to the staff, reminding them to complete the survey. During the following 2 weeks the researcher visited the healthcare centers and collected the completed surveys. Also, at one location of the organization the survey was administered to medical providers during a staff meeting.

Upon checking in with the receptionist patients were alerted that they have the option of completing a survey prior to or after receiving medical care. In addition, an English–Spanish bilingual assistant visited the location and explained the survey to all patients upon check-in. The patients then returned the completed survey to the receptionist at the front desk.

#### 2.4. Data analysis

A Pearson correlation coefficient was used to test the predicted positive relationship between the independent variable empathy and the dependent variable intercultural communication competence in Hypothesis 1. Hypothesis 2, which predicts bilingual medical providers to regard themselves as more competent utilized analysis of variance (ANOVA) between the ICCC scale and bilingualism. Hypothesis 3 was also examined using ANOVA between the provider ICCC scale and intercultural experience. Lastly, for Hypothesis 4 a *t*-test for independent samples was used to measure the predicted difference between medical providers’ self-reported ICCC and patient-perceived medical providers’ ICCC.

### 3. Results

Hypothesis 1 which predicted a positive relationship between empathy and intercultural communication competence among medical providers was confirmed. This analysis showed a moderately strong positive relationship ( $r = .45$ ), with a sample size of 45 and a significance level of .002. It was also shown that empathy accounts for 20% of the variance within intercultural communication competence ( $r^2 = .20$ ).

There was also a strong positive relationship between empathy and intercultural communication competence in the perceptions of patients. Patients feel that empathetic medical providers are also competent intercultural communicators. A Pearson correlation coefficient was used to test the predicted positive relationship between the independent variable empathy and the dependent variable intercultural communication competence in Hypothesis 1. This analysis showed a strong relationship ( $r = .53$ ), with a sample size of 91 and a significance level of .001. In addition empathy accounted for 35% of the variance among patients ( $r^2 = .35$ ) (Table 1).

Table 1  
Correlation between empathy and intercultural communication competence

Group	<i>r</i>	<i>p</i>	<i>N</i>
Medical providers	.45	.02	45
Patients	.53	.01	91

Significance levels were at  $p < .05$ .

### 3.1. Bilingualism and ICCC

Hypothesis 2 posited that bilingual medical providers would regard themselves as more competent intercultural communicators when compared to monolingual medical providers. This hypothesis was disconfirmed; there is no statistically significant relationship between bilingualism and intercultural communication competence. The provider ICCC scale was used in an ANOVA means test with the variable bilingualism ( $F = .66$ ,  $df = 1$ ,  $\eta^2 = .02$ ,  $p = .42$ ). The mean ICCC among bilingual medical providers was  $M = 3.79$ ,  $SD = .48$ , while it was  $M = 3.58$ ,  $SD = .37$  for monolingual medical providers. Although the means do show higher levels of intercultural communication competence among bilinguals, the results are unable to be generalized to the sample from which they were taken. However, according to the power of  $F$ -test ( $\alpha = .05$ ;  $u = 1$ ) on means in the ANOVA there is a 65% chance of detecting a medium effect between intercultural communication competence and bilingualism. In other words, the insignificant relationship shown through ANOVA may be due to inadequate power within the sample and a relationship may actually be present.

### 3.2. Intercultural experience and ICCC

Hypothesis 3 predicted medical providers with more than three months intercultural experience would consider themselves more competent in intercultural communication than providers with less than three months of intercultural experience. The hypothesis was confirmed; there is a positive significant relationship between intercultural experience and ICCC. The provider ICCC scale was used in an ANOVA means test with the variable intercultural experience ( $F = 5.83$ ,  $df = 1$ ,  $\eta^2 = .15$ ,  $p = .02$ ). Individuals who have lived outside the United States for a period of longer than three months demonstrated higher levels of intercultural communication competence ( $M = 3.94$ ,  $SD = .35$ ) than those who have lived outside the United States from 0–3 months ( $M = 3.59$ ,  $SD = .50$ ) (Table 2).

### 3.3. Self-reports and receiver-reports

Hypothesis 4 posited that medical providers self-reported ICCC would be different than patient perceived medical providers' ICCC, this hypothesis received marginal support. To test this hypothesis a competence scale was constructed from the patient survey. This scale consisted of 13-items relating to ICCC including

Table 2  
ANOVA effects of intercultural experience on ICCC among medical providers

Intercultural experience	<i>F</i>	<i>df</i>	<i>P</i>	<i>M</i>	<i>SD</i>
+ Three months	5.83	1	.02	3.94	.35
– Three months	5.83	1	.02	3.59	.50



Table 3

Means and standard deviations on intercultural competence measure (higher score = greater perceived competence)

Group	<i>M</i>	SD
Medical providers	3.75	.50
Patients	3.68	.94

knowledge, skills, comfort, motivation, accomplishing communicative goals, and reducing misunderstandings. The mean from this scale was then compared to the mean from the provider self-report scale of ICCC through using a *t*-test for independent samples ( $t = .13$ ,  $df = 134$ ,  $p = .04$ ). Providers ( $M = 3.75$ ,  $SD = .50$ ) rated themselves slightly higher than patients did ( $M = 3.68$ ,  $SD = .94$ ), with a minimum score of one and a maximum score of five (Table 3).

#### 4. Discussion

The most significant finding of this study is that empathy is positively related to intercultural communication competence based on both providers' and patients' perceptions. The results of this study identify empathy as a primary component of intercultural communication competence in the healthcare environment. Medical providers who possess the abilities to listen well and place themselves in the patients place are motivated, knowledgeable, skillful, appropriate and effective when communicating across cultures. This finding supports the work of Bennett (1979) and Gudykunst (1993) that empathetic individuals are also competent intercultural communicators. This finding differs from previous research in that the relationship between empathy and intercultural communication competence has been determined to exist in the healthcare context. Also, this study has shown a stronger relationship between empathy and intercultural communication competence in receiver-reports when compared to self-reports. Among providers, empathy accounted for 20% of the variance within intercultural communication competence and among patients empathy accounted 35% of the variance. This suggests that empathy is more important to intercultural communication competence in the view of patients than in the perceptions of medical providers. The percentage of variance also suggests that intercultural communication competence is largely composed of empathy in the opinion of patients.

There is an important reason as to why empathy is positively related to intercultural communication competence within the healthcare field. Many medical providers realize the need to be empathetic when providing medical care, considering that patients often visit providers at a very vulnerable time in their life. A visit to clinic or hospital often means that a patient has exhausted all attempts to care for his or herself at home. Combine this with the fact that many people are uninsured and unable to afford healthcare, an appointment with the

doctor can be a time of high anxiety increasing the importance of empathy among medical employees.

This investigation did not establish a significant relationship between bilingualism and intercultural communication competence thereby failing to confirm the research by Gudykunst (1992) and Nishida (1985). This may result from the large number of medical providers in this study who are fluent in a second language compared to the small number of providers who are not. Also, the actual medical skill of a provider may be more important to intercultural communication competence than his or her ability to speak a second language. The technical skills needed to effectively administer medical treatment may outweigh any language differences. As a result a relationship between bilingualism and intercultural communication competence cannot be generalized to similar healthcare contexts. However, more research is needed in this area considering the Power of *F*-test indicates that it is likely a moderate effect exists between the two variables.

The results from this study indicate that intercultural experience greatly improves a medical provider's ability to communicate with patients from cultures different from their own. Data analysis from this study confirmed the work of Martin (1987) by substantiating a relationship between intercultural experience and intercultural communication competence. Participants who lived outside the United States for a period of more than 3 months demonstrated significantly higher levels of intercultural communication competence. It was demonstrated that participants with intercultural experience were 15% more competent in intercultural communicators than those without intercultural experience ( $\eta^2 = .15$ ). While short-term international travel has been shown to improve attitudes toward the host culture, intercultural knowledge is gained from a more in-depth immersion in a new cultural environment (Fisher & Price, 1991; Moir-Bussy, 2003). As research by Billingmeier and Forman (1975) showed extended experience outside of one's own culture has a lasting effect on the individual's intercultural knowledge and overall view of diverse cultures.

This study also illustrated that self-perceptions of intercultural communication competence are higher than other-reports of intercultural communication competence among medical providers and patients. Past research has not explicitly stated that self-reports of communication competence are inflated when compared to other-reports, but concern has been expressed in relation to which type of measurement is optimal (McCroskey & McCroskey, 1988; Ruben, 1989). While medical providers in this study reported they are only slightly better intercultural communicators than patients perceive them to be, this discrepancy should still be noted as it may clarify which type of measurement is most effective in the area of intercultural competence and healthcare. In addition, this finding elicits concern as to whether self or other reports of intercultural communication competence are most important in the healthcare setting. It seems that the other reports are imperative considering patients actually receive the medical treatment and are more negatively affected by incompetent communication. Consequently, their perception of intercultural communication competence should have priority over the self-reports of medical providers.

#### *4.1. Implications of findings*

Much of the literature in the area of intercultural communication competence has focused on sojourner adjustment and relational behavior (Imahori & Lanigan, 1989). This study has implications for intercultural communication competence research in that it provides empirical evidence to extend previous findings by other researchers to the healthcare environment (Gudykunst, 1985; Ruben 1976; Spitzberg & Cupach, 1984). Extending communication competence research into the healthcare environment is of great importance. Healthcare is one arena of communication research in which ineffective communication can have tragic consequences for all involved. While medical providers must have the technical ability to successfully treat patients the intercultural skills are just as important to increasing the likelihood of patient satisfaction and compliance. If the intercultural skills are lacking the messages sent by the provider to the patient will not register, decreasing the likelihood of successful treatment.

Prior to this study it was unknown if the factors of intercultural communication competence such as motivation, knowledge, skills, empathy, and reducing misunderstandings are equally important in the healthcare context as they are in the sojourner or relational setting. It can now be stated with some confidence that empathy is extremely important for medical providers to effectively communicate with patients from cultures different from their own. It should also be stated that a reliable scale of intercultural communication competence among medical providers was discovered, largely consisting of items measuring motivation, anxiety, and knowledge. This demonstrates that these variables are also important facets of competence in the healthcare field.

Results from this study have a number of implications for other healthcare organizations as well. These organizations can now identify factors such as empathy and intercultural experience that contribute to the communicative abilities of their staff. Also, other organizations may consider compiling a multicultural and multilingual staff as this study showed employees with these capabilities are more effective intercultural communicators. Additionally, this study encourages organizations to obtain patient feedback that provides information about the ability of their medical staff. As the differing perceptions of competence between patients and providers illustrated self-perceptions of competence may differ from other reports. Finally, this study may encourage healthcare organizations to support intercultural activities for their staff. Medical supervisors may encourage potential employees to take foreign language classes or study abroad while completing their education.

#### *4.2. Limitations*

A drawback of this study is the limited number of participants representing both the patients and providers. In addition, the sample was overwhelmingly composed of females. This may be due to the fact that women are more likely than men to be employed as medical assistants and nurses, or seek medical treatment for illness. However, the limited number of males in this sample is likely typical for patients and

medical providers at other healthcare organizations. Research has demonstrated that men are less likely to seek medical treatment and comply with recommendations from medical providers, leading to increased rates of stress-related disease (Burgoon & Kingle, 1998).

An additional limitation that should be considered is that the research took place in Southern California, an area much more diverse than most of the United States. Individuals in this area are more likely to be exposed to other cultures and may be more competent intercultural communicators. It is possible that living in California can itself be considered an intercultural experience.

Finally, the organization that this study examined may be atypical of most healthcare organizations. A large number of the medical providers (82%) speak a second language. It is unlikely that such a high percentage of medical providers in other healthcare organizations possess such high levels of second language ability. As previous research has demonstrated a relationship exists between bilingualism and intercultural communication competence. Therefore, the providers in this study may have high levels of intercultural competence not indicative of most medical organizations

#### 4.3. *Future research*

The results of this study have generated a number of questions relating to intercultural communication competence and healthcare. Additional research should examine the link between second language ability and competence, a non-significant finding in this study. A sample size that includes a somewhat equal number of monolingual and bilingual participants should be constructed to compare the difference in levels of intercultural communication competence. Research should also examine the effect specific languages have on intercultural communication competence.

This study also has implications for the study of nonverbal communication and intercultural communication competence. The questionnaires did not have items that investigated the ability to effectively communicate through nonverbal behaviors such as haptics, oculesics, or proxemic behavior. Previous research has shown that cultural differences exist in the use of nonverbal communication. More specifically cultural variation exists in the manner in which cultures touch, utilize interpersonal space, react to time, and move their bodies (McDaniel & Andersen, 1998; Richmond & McCroskey, 2004). Therefore, the manner in which a provider interacts nonverbally may have an effect on their level of perceived intercultural communication competence. For example, a provider from a monochronic culture will likely regard schedules and timeliness as most important, while a provider from a polychronic culture may view time more informally (Andersen, 1999). Considering this, more research is needed to explore the influence of nonverbal communication on intercultural communication competence in the healthcare setting.

Finally, a more definitive meaning of intercultural experience should be examined. In this study it was defined as an experience abroad lasting three or more months. Given the diversity of many areas within the United States an individual could have

an intercultural experience without leaving the country. A study could then be administered that investigates differences between intercultural experiences in one's homeland compared to experiences outside of one's homeland.

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