

Cross-Cultural Health Communication

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ABSTRAK

Setiap kebudayaan memiliki pandangan yang beragam tentang kesehatan atau penyakit, kehidupan atau kematian. Ada masyarakat yang menganggap penyakit sebagai nasib yang harus diterima secara fatalistik. Ada pula masyarakat yang memandangnya sebagai cobaan dari Tuhan, dsb. Selain itu, terdapat juga perbedaan konsep untuk menamai jenis penyakit tertentu pada sejumlah pengguna bahasa yang berbeda. Nama suatu penyakit dalam suatu bahasa tidak bisa diterjemahkan langsung ke dalam bahasa lain. Dokter berkebangsaan Amerika, misalnya, akan kebingungan bila menangani pasien orang Indonesia yang berpenyakit "raja singa", karena nama penyakit itu tak bisa diterjemahkan langsung menjadi "king lion". Keragaman budaya ini berimplikasi pada para petugas kesehatan, perawat, dokter, untuk memahami budaya pasien, yang ditanganinya, yang berasal dari komunitas budaya berbeda. Kekeliruan memahami latar belakang budaya pasien dapat menimbulkan kesalahan dalam mendiagnosis penyakit, menangani pasien, atau menentukan resep obat.

There are many ways how illness is defined, how it is to be treated, and how people involved in health care interact with each other. In some Asian and African countries, illness is often considered as a punishment from God for the wrong deeds, as believed by some Hindus. In Muslims' eyes, illness can be perceived as a trial from God to clean their sins or to get a reward from Him. Muslims believe strongly that prayers can help them to cure illness. The Japanese medical health providers are accustomed to concealing a patient's terminal illness. In the Netherlands patients suffering from incurable illness are allowed to commit suicide (*euthanasia*).

People from different cultures also see life and death differently. Hindus in India do not consider death as the ultimate reality for those left behind. According to their belief the deceased will be reborn soon in his or her next life. Although Christians believe in salvation and heaven, they see death as an unhappy event (Samovar and Porter, 1991:256). According to Islam, death is not something to be scared of as long as Muslims are pious. It is perceived as the gate to heaven, an eter-

nal beautiful place beyond one's imagination.

Like in many non-Western societies, Muslims believe in close connection among the body, the mind, and the soul. Thus, sickness can be perceived as a symptom of the imbalance in the interconnectedness among these three aspects. This means that to cure physical disturbance, the mind and the soul must also be restored. Based on such a belief in Indonesia which is predominantly Muslim, many people seek alternative treatments offered by Muslim clergymen to cure their sickness. Often this spiritual treatment is carried out through chanting "holy verses" and prayers.

Interestingly, some people in Indonesia also believe that eating Cobra meat, drinking its blood, and swallowing its bile can cure certain kinds of illness. Taiwanese, even those who live in western countries, believe that hairs of certain rare turtles can cure cancer, while Chinese have used tiny sea animals called the seahorses to cure their heart and kidney nuisances in addition to eating other animals' organs to cure other kinds of illness. (No wonder the population of the seahorses has dropped from time to time. So some people con-

cerned with the survival of these tiny animals have made efforts to protect them). The Chinese's preference to traditional healing (herbs and acupuncture) over modern medical treatment makes them reluctant to take modern medicine (pills) and to undergo surgery. It is worth noting that among some African tribes, spitting is believed to cure sick people.

In Mexico dominated by Catholicism, Mexicans tend to be fatalist; they accept illness as their fate, that they do not strive hard to overcome their health problem. In contrast, Protestants believe more strongly in rational efforts to get over their health problems, so they rely more on modern medical practices than on prayers alone. Meanwhile, many people in traditional societies in Asia and Africa still rely on "traditional spiritual healers" (in Indonesia they are called *dukuns*) to cure their illness. In Indonesia, occasionally the treatments carried out by these traditional spiritual healers to cure sick people are sometimes irrational, for example bathing them at night, using water complemented with various kinds of flowers. The *dukuns* often provide the patients with some amulets to get healthy or to counter the coming illness, in some cases, if the *dukuns* are men and the patients are women, the *dukuns* will manipulate the women, asking them to have sex with the men. Lay persons may also hold sloppy practices to cure sick people, imitating the practice of the *dukuns*. Once in Subang, West Java, a man took his wife assumed to be insane to a pool near by at night. He bathed her with cold water from the pool in order to cure her madness. Instead of being recovered, the woman died due to coldness.

In collectivist (eastern) societies human communication is more complex than in individualist (Western) societies. A nurse from the Philippines in USA once asked an American doctor to give certain medicine to a patient. Although the nurse was aware that the doctor had given the wrong medicine that would harm the patient, the nurse was forced to follow the doctor's directive without resistance (Irislin and Yoshida, 1994:53). The nurse's behavior is consistent with a collectivist value that nobody is supposed to criticize his or

her superior openly that will make him lost his face. Whenever possible, the actions of all the members are coordinated in a harmonious way to guarantee the stability of society.

In a strict Muslim country like the Arab Kingdom where men are more dominant than women and men consider women as their honor (thus women must guard their chastity), a male doctor or a male nurse is not allowed to examine female patients, especially if the health-care practitioners have to touch them or examine private parts of their bodies.

Defining Communication

Communication is the process of sharing meaning through verbal and nonverbal behavior (Levine and Adelman, 1993:xvii). Communication is the creation of meaning between two people or more (Tubbs and Moss, 2001:5). So in a broad sense communication can be defined as the sharing of experience. To some degree, all animals also share their experiences with each other, but human communication is unique in the sense that in doing so they use symbols. A symbol is something used to represent something else. A symbol is arbitrary: anything can be used as a symbol to refer to something else as long as it has been agreed upon by a community. Thus, there is no absolute or natural relationship between a symbol and what is symbolized. For example, we can agree to call a certain animal a cat, without the presence of such an animal. To ask how someone is after a long separation, an American (based on the consensus with other Americans) says, "How are you?"; a German, "Wie geht es?"; an Indonesian, "Apa kabar?"; a Japanese, "Ogenki desuka?"; an Arab, "Kaifa halak?" A symbol can even represent a more abstract concept or idea, for example the swastika (Nazi ideology), the cross (Christianity), the moon and the crescent (Islam), or the following words:

Freedom, peace, capitalism, or communication. In short, symbols may include words, jargons, gestures, pictures, styles (clothes, hair), or objects (status symbols) that are meaningful and recog-

nized by those who belong to a culture (Hofstede, 1994:7).

In a sense communication is an exchange of significant symbols. Through the use of these symbols, people can share ideas and information without presenting the things being discussed before them. Through symbolization, people can abstract realities and can grasp what other people know or think. Communication occurs once a person conveys a (verbal or nonverbal) message and stimulates another person's (verbal or nonverbal) response without ascertaining whether both persons use the same set of symbols and whether the response of the message receiver fits the expectation of the message sender. Following Pace and Faules (1998:26), communication consists of two general kinds of action: first, message display, and second, interpretation of the message. In this context, the message display can be intentional or unintentional. However, in cross-cultural communication, it is more useful to conceive that intention is not a necessary condition for communication to take place, since it is difficult to define intentionality. Whatever one does, even without saying anything, one's behavior has a potential to be interpreted as long as other people are present and observe the behavior. One's silence is also a message when it is interpreted by another person as, say, agreement, disagreement, disappointment, frustration, stupidity, etc. Thus, *one cannot not communicate*.

The definition of communication implied in cross-cultural communication must be broad enough to cover nonverbal communication which is a dominant part of cross-cultural communication and often happens beyond the awareness of the communication participants. These nonverbal behaviors may include a raised thumb, a nod, a smile, a laughter, a wink, a stifled body posture, etc. In other words, a response to a message may vary, from a conscious, open (overt) message, such as a shout, "Please, come here!" to an unconscious, biological response involving changes of chemical composition in our body, such as the decline of body temperature (cold hands), sweats rolling down cheeks, hands trembling, the enlargement

of eye pupils, etc. Between those two extremes there are other variants such as our (less-conscious) roles, waving hands, shaking head, etc. (see also Littlejohn, 1996:7-8).

Culture and Communication

Communication involves expectation, perception, choice, action, and interpretation (Condon and Yousef, 1985:33). Every time you communicate with someone, there is no doubt that he or she comes from a cultural environment. This means that what he or she says and the way he or she behaves is influenced by his or her culture, although this does not mean that all members of the culture behave in exactly the same. Yet, we will find more or less the same pattern or similarity in the attitudes and behaviors of the members of the same culture: what they do the first time they meet people; how they address people (using their titles or not); what topic of conversation is suitable in a certain situation; whether they touch others or not.

There are also other issues to be considered when we encounter people from different cultures. Do people mean what they say and say what they mean? Is eye contact necessary? How much is lateness tolerated? Do we have to speak in a loud or soft voice in a situation or to a certain person? etc. Without knowing their culture and the important values implied in the culture, it is difficult for us to predict their behaviors: whether they will shake our hands or bow when we meet; whether we should see their eyes when we talk; whether we should talk seriously or we include some anecdotes in our talk; whether we must give priority to women to enter a room or to eat; whether our attire should be formal or informal when we attend dinner, etc. Our thinking patterns will get stucked if the culture dictating our partner's communication behavior is different from our own.

People communicate to adjust themselves to the environment. Adjustment does not mean that we have to agree with or imitate all other people's actions. Rather, we must try to understand reason behind their actions without ourselves being intimidated by the situation. So we have to make

efforts to communicate effectively with people from different cultures in at' arenas of life: education, business, politics, sports, tourism, health, etc. The problem is that most of us think that the way people think similar to ours is right, and that different from ours is wrong. We are not always aware that there are various ways of conceiving what the world is like. Put in another way, people tend to have stereotypes about others different from them. A stereotype is overgeneralization about specific groups of people (Brislin and Yoshida, 1994:42). For example, English people are reserved; Americans are kind but loud; Italians are emotional; Germans are rigid.

The problems of communication mentioned above seem to exist in health communication, let alone in cross-cultural health communication. Doctors, nurses, and patients can be considered as separate groups of people, each of which has its distinctive culture and cognitive styles affecting the way its members communicate verbally and nonverbally with others. The problems will become more complicated if the people involved in health communication come from different social, ethnic, racial, or religious backgrounds, with different languages, worldviews, beliefs and values. Certainly the way the message is encoded and the way the message is interpreted are influenced by the elements inherent in the communication participant's culture.

Culture tells its members what makes people ill or why they are ill, what should be done to get over the illness, and what words are used to describe symptoms of the illness and explain the causes of the illness. Each cultural group seems to have its typical set of ideas regarding illness and ways to cure it. So interacting with people from different cultures will not only help us to understand other cultures but also our own culture, including cultural knowledge, beliefs, and values about health not shared by others. Unfortunately, we are not always aware of the importance of delaying our judgement of other cultures after we judge our own culture (or keep a distance from our culture) so that we can really see the strengths and the weaknesses of our culture and become

more sensitive and tolerant to cultural differences. Lack of knowledge about how other cultures conceptualize health, illness, and treatment will result in misperception and miscommunication among health-care practitioners who come from different cultures but work in the same hospital and treat the same patients. The situation will be worse if the patients also have different ideas about their illness and its treatment. This will in turn lead to misdiagnosis, improper procedures, or dangerous treatment causing the patients' death. So effective communication is imperative to settle health problems among those involved in the patients' recovery.

Due to the importance of effective communication, some medical professionals whose expertise is not communication begin to study effective communication. Dr. Jack Ryan, a medical doctor who once chaired an association of hospitals in USA said that doctors had bad communication skills then and so they could not speak to patients. He said he had strived to be a good speaker because effective communication made him an effective doctor (Mulyana, 1996:xi). There is no doubt that in today's world, since people (including doctors, nurses, and patients) from different cultures interact more intensively they have greater needs to understand how communication works, how culture affects the way they communicate with each other, and most importantly to acquire skills to communicate effectively with people from different cultural backgrounds.

Defining Culture

Every communication practice essentially represents culture. Put in another way, communication is a map of a complex reality of culture. Communication and culture are closely related as if they are two sides of the same coin. Edward T. Hall (1973) argues that "culture is communication" and "communication is culture." Communication cannot be separated from culture, since as soon as we begin to talk about one we are almost inevitably talking about the other (Condon and Yousef, 1985: 34). In a way, the essence of culture is communi-

cation, since culture emerges through communication. Without communication, cultures does not exist.

Culture is a slippery concept. It can be defined in various ways. Hofstede (1994:5) defines culture as “the collective programming of the mind which distinguishes the members of one group or category of people from another.” Hofstede adds that culture is learned, not inherited. He also states that values are the core of culture, while symbols (words, gestures, pictures, dress, hair style, flags, status symbols or objects that carry a particular meaning) are the outer and most superficial layer of culture.

Larry A. Samovar and Richard E. Porter (1991) put forward six categories constituting culture that affect our communication with people from different cultures, namely:

Beliefs, values, and attitudes

World view

Social Organization

Human nature

Activity Orientation

Perception of self and others

Culture can also be seen as an iceberg (the iceberg of culture). There are parts of culture that are observable, such as behaviors, appearance, habits, language, and dress while others are not observable such as thought processes, assumptions, values, space orientation, time orientation, expectations, and perceptions. Still other parts might or might not be observable, such as: customs, beliefs, and traditions (see Appendix 2 on the Iceberg of Culture). Behavior is on the top of the iceberg of culture, since this element is the most observable one, while thought processes are on the bottom, because these cannot be seen at all. All the cultural aspects mentioned above are related to each other, although we can discuss each one separately. Let us now discuss some important elements of culture and how each element affects cross-cultural health communication.

Beliefs and Cross-Cultural Health Communication

A belief is a subjective assumption that an object or an event has certain characteristics or values, with or without evidence. Some of our beliefs are: AIDS is deadly; taking shower at night can cause cold; uncooked water is better than cooked water; number 13 is danger. More specifically, inhabitants in Kecamatan Pagimana, Banggai Regency, Central Sulawesi are accustomed to drinking uncooked water. They believe that boiled water—which they call dead water—is not delicious and fresh. Health workers in time area assume that this belief is a barrier to be solved, since this custom causes diarrhea leading to death among the inhabitants (Suartika, 2000). This belief is similar to that of a Los Molinas community in Peru, who do not want to drink cooked water, since according to their belief the boiled water is only suitable for sick people. They even believe that boiled water has lost its essence for the survival of the people, and can make people weak to strive in their life (Rogers, 1995:1-5).

Japanese consider that four is an unlucky number and is often associated with death. Imagine how a Japanese patient feels when she finds Out that she is being wheeled into the operating room number four in an American hospital. She might scream in panic. Interestingly, the same number means something favorable for a Navajo Indian. He is just happy when he knows he is being taken to the same surgery room. Traditionally Navajo Indians indeed believe that much of the world is built on the number of four: four directions of the earth; they adore four holy mountains; and they repeat the phrases four times in their ritual chants.

In related to health, different cultural groups may believe in different causes of sickness and different ways of curing sickness. Some people, such as Americans assume that illness is caused by a virus, bacteria or the dysfunction of body organs, so they rely on empirical explanations and assume that illness can be explained scientifically. For example, many Americans believe that AID is

caused by a certain virus and hence can be cured if they can discover the actual cause of the disease and produce the right medicine to cure it.

Some people believe that illness is the result of God's intervention. Based on this view, one may consider that his illness is caused by his own bad deeds in the past, its purpose being to warn him to stop the evil deeds or to compensate for his sins or just to remind him to improve his duties to worship God. Many Muslims believe that AIDS is a punishment given by God to the people transgressing His laws (that homosexuality and sex outside marriage are forbidden by Him), and they believe that people will never be able to find medicine to cure AIDS as long as homosexuality and fornication (adultery) causing this disease still exist. In other words, in Muslims' perception, the best and only solution to eradicate AIDS is to prevent ourselves from homosexuality and sex outside marriage.

In many countries in Asia and Africa many people still believe that illness is caused by evil spirits or magical powers produced through sorcery or witchcraft. In Indonesia in particular, this tendency has been indicated by the fact that certain people have been accused as *tukang santet* (witch or sorcerer) causing illness, some of them have been killed by the people. It is believed that *tukang santet* can insert needles or nails into stomachs of the victims. Some Indonesians may think that sick babies or children have been caused by satans. To counter such illness, they may ask traditional spiritual healers (*dukun*) to help them. These traditional spiritual healers may use traditional medicine (herbs), plain water possessing a "magic formula," and or carry out certain rituals (including chanting).

Many Indonesians believe that even bad winds can cause sickness. If this happens, the sick people usually ask others to drive out the wind through coining, that is, a coin is used to rub on the body of the sick person: the back, the neck, the stomach, the chest, and the arms. Western people think that such a curing practice is abnormal. They see the marks left in the body as the result of coining as physical abuse, especially

when the sick are children (see also Samovar and Porter, 1991:260).

Values and Cross-Cultural Health Communication

A value is an evaluative component of our beliefs incorporating: utility, goodness, esthetics, and satisfaction. So values are normative, informing members of the culture what is good or bad, right or wrong, what we struggle for, what we are afraid of, etc. Some people believe that money is the most important source of success, so they run for it day and night, regardless of the way they make money. Others believe that peace of mind is the most important source of happiness, so they always try to avoid committing crimes and evils.

In some traditional countries in Asia, Africa and Latin America, males are valued higher than females. So a family may seek a serious medical help when their son is sick. They may spend much money as demanded. Yet, when their daughter is sick, they do not make the same effort. The family may even regret why their son died instead of their daughter. In such countries, money or property may also be valued higher than health. So when one family member, even oneself, is suffering from terrible illness and needs immediate surgery, still he or she is taken care of at home rather than in the hospital, because the *family* or oneself does not want to spend much money. The reluctance to spend the money for the patient's treatment in the hospital is greater if the family adheres to fatalism, believing that sickness is a destiny to be accepted.

In some countries women are not always accompanied by their husbands when delivering babies. While it is customary for the husbands to do so in western countries, it is not so in some Asian, Middle-Eastern, African, and Latin American countries. For an Arab man or a Mexican man, a woman delivering a baby is considered as "unclean," so he avoids her. Instead of accompanying her in her bedside, the husband may ask his mother, his mother-in-law, his sister, or his sister-in-law to do so. He will touch his wife again when she is already clean. While in western societies,

childbirth is a private occasion, in many Asian and Latin American countries, childbirth is a social occasion. So many neighbors, relatives, and friends will visit the family who has *the* new baby and bring them gifts. A Muslim family in particular is supposed to hold a religious ceremony called *aqiqah* when the baby is one week old. In this event the baby is given a name. The family may invite others to have meals and celebrate the event and or distribute sheep meat to poor people in the neighborhood.

Worldview, Religion, and Cross-Cultural Health Communication

Worldview is our cultural orientation toward our position in the universe, God, life, death, universe, truth, wealth, and other philosophical issues. Worldview includes religion and ideology since they often influence us how to understand and respond to those issues. Islam for example dictates that Muslims eat *halal* (allowable) and good food to stay healthy. They are not allowed to eat pork or ham and to drink alcohol because they believe that such food and alcoholic beverages are not healthy. Many Muslims will not consume medicine containing alcohol. Meanwhile, in many countries, there are millions of vegetarians. They do not eat meat, at all. These people believe that any kind of meat is not healthy for the human body. Besides, they consider that meat means killing animals.

Many Muslims, especially in the Middle-East, insist that only female doctors and female nurses be allowed to examine female patients, including those who deliver babies. The male doctor's examination of the woman's naked or half-naked body is considered as degrading the honor of the woman as well as that of her husband or the family in general. Because women are told by their families to be pure and modest, they may be reluctant to seek medical help from male health-care practitioners, although their sickness is serious. Their health problems may become worse if they cannot find any female health practitioner, especially female doctors. In reality, even in western countries

where women may develop their careers as they wish, medical doctors are predominantly men, let alone in other less-developed countries.

In countries where authority is in the hands of men, even in non-Muslim countries in Asia, Africa and Latin America, it is not always easy for doctors and nurses to treat female patients, for instance, whether they have to operate on them, even though their illness requires such critical treatment. It is men (husbands or fathers) who make the decision on the treatment of their wives or daughters. Doctors and nurses may face uncertainty when they must take a quick action in the absence of the patient's husband or father.

Language and Cross-Cultural Health Communication

Communication among Asians is predominantly high-context. That is, most of their communication messages are implicit. Their nonverbal messages are often more meaningful than their verbal messages. When they say "Yes," it does not necessarily mean agreement like in North America. While North Americans—their communication is low-context—say "Yes" to mean agreement, often Asians say "Yes" to mean "I don't know" or even "No." So miscommunication between American health-care practitioners and Asian patients may occur, as illustrated by the following case.

Linh Lee, a sixty-four-year old Chinese woman [was] hospitalized for an acute evolving heart attack. At discharge, her physician suggested that she come back in two weeks for a follow-up examination. She agreed to do so, but never returned. It is likely that she never intended to do so but agreed because he was an authority figure. Chinese are taught to value accommodation. Rather than refuse to the physician's face and cause him dishonor, Mrs. Lee agreed. She simply did not follow through, sparing everyone embarrassment. When Nancy, her Chinese-American nurse, saw her in Chinatown several weeks later, Mrs. Lee was very cordial and said she was feeling fine (Galanti, as cited by Geist, 2000:349).

Western medical practitioners must be vigilant when they treat Asian patients. An Asian patient may not tell his or her sickness frankly especially if the sickness is related to private parts of his or her body. The tendency to keep a personal problem as private is more common among women, especially if the health-care practitioners before them are males.

Interaction between medical practitioners and patients is complicated if they speak different languages (mother tongues). Even when interpreters are used, misinterpretation may still arise. When a medical doctor misinterprets what his patient says, his misinterpretation may lead to misdiagnosis. This will in turn lead to wrong medication which will put the patient in danger.

Language represents culture. Certain words used in one language cannot literally be translated into another language. Words related to diseases may even be tricky. Think for example some Indonesian words related to symptoms of sickness, diseases, medicine, and treatment. *Penyakit raja singa* (meaning a contagious sexual disease) cannot be translated into *the lion king disease*. *Penyakit kuning*, meaning (symptoms of) a liver disturbance cannot be translated into *yellow disease/illness/sickness*. It is incorrect to use the word *hot sickness/illness* as translation of *penyakit panas*. It is also mistaken to think that *obat merah* in Indonesian is *red medicine* in English. Rather, *obat merah* means iodine. Problems of language literal translation in health care can be seen in the following case.

[Vietnamese] words that translate “feeling hot” don’t mean “fever.” What they mean is “I don’t feel well” and generalized malaise. And if you should ask your Vietnamese patients, “Have you ever had hepatitis?” the translator [may] translate that into “liver disease,” and liver disease in Vietnam means itching. . . . Similarly, the kidney is the center of sexual potency to Indochinese and Vietnamese, and therefore “kidney trouble” may really mean decreased libido or other sexual difficulty (Fitzgerald, cited by Geist, 2000:350).

While patients describe symptoms of their sickness in a vague way, medical jargons (such as

arthritis, insomnia, dementia, '2nesthesia, etc.) used by doctors and nurses may confuse patients. So it is important that they use common understandable words.

Nonverbal Behavior and Cross-Cultural Health Communication

Gestures vary from culture to culture. So do their meanings. The “okay” sign in the United States (forming a circle by a thumb and a forefinger while three other fingers stand) is vulgar and rude in some Latin American countries. In Brazil, like in Greece, it means a sexual invitation. Yet, the same sign means money in Japan. Imagine an American male doctor who gives the okay sign to a Brazilian female patient or a Greek female patient in an American hospital. This may result in a bad relationship between the two parties. Even a head nod does not always mean agreement. For Bulgarians and South Indians, head nod means “No,” while shaking head means “Yes.” Again, an American doctor who asks a question to a Bulgarian patient or an Indian patient from Bombay will misinterpret the patient’s head shaking which means agreement rather than disagreement.

Some cultural groups in Asia, the Middle-East, and Latin America like touching. It is common among Mexican men to embrace each other when they meet. Arab men even kiss each other on the cheek in their encounters. However, touching among the same sex is avoided by Americans and most of other Westerners. They consider this behavior is too intimate; it may connote sexual attraction (homosexuality among men and lesbianism among women). So based on their culture, Mexican patients expect their American doctors to touch them, at least when the patients stay in bed. Without understanding the Mexican culture, American doctors may be reluctant to touch their Latin American patients. Touching is so commonplace in Mexico that if you like Mexican babies, you must show your liking by touching them. Admiration or love to a baby without a touch is believed to invite the “evil eye” and harm the child. In contrast, American mothers (who do not like

touching) discourage others to touch their babies; they' assume that hands used to touch their babies might contain germs and thus will harm the babies.

Eye contact is another aspect of nonverbal behavior. To show respect, most people in Asia and Africa do not maintain eye contact when they communicate with older people or people who have higher status. However, this behavior is often misinterpreted by North Americans. Americans see straight the eyes of their communication partners to show their goodwill and sincerity. Their behavior is often perceived as dominance by those people accustomed to lowering their gaze. Misunderstanding may take place between Black Americans who lower their gaze in their communication with their White superiors who maintain eye contact. The *White* Americans will consider the behavior of the Black Americans as dishonesty, shyness, or inferiority. White American doctors may dislike Black, African, or Asian subordinates who lower their gaze, although their behavior is intended to show respect to them.

Physical distance between interactants (medical practitioner and patient) is also symbolic and culture-bound. For example, Latin American people stand closer to each other than Americans. But the physical distance the Arabs keep between each other is closer than kept by Latin Americans. The normal, comfortable physical distance for the Arabs will be perceived as (sexually) aggressive by Americans. So an American doctor will feel uneasy when an Arab patient stands too close to him to feel comfortable. On the other hand, the Arab patient will consider the American doctor as too aloof.

To keep the physical distance, and also the status distance, a doctor usually puts a barrier in the form of a desk between himself and his patients. But in fact this makes many patients feel uncomfortable. Physician Abraham While conducted an informal experiment in which he attempted to determine whether removing the desk as a barrier between doctor and patient would have any effect on the way in which patients conducted themselves in an interview, he found that with the

desk removed, 55.4 percent of the patients sat "at ease." With the desk in place, only 10.8 percent of the patients manifested relaxed positions (Rich, 1974:168).

Concluding Remarks

Clearly cross-cultural communication in health is important to consider. A patient's recovery "can be enhanced or hindered, depending on the communication that takes place between care giver and patient" (Bowman, cited by Geist, 2000:342).

Without sufficient understanding of health communication ii: general and cross-cultural health communication in particular, potential problems will arise among medical practitioners, patients, and patients' families. Doctors and nurses in particular have the responsibilities to comprehend how cultures affect the way patients define their sickness, its symptoms, and the way to treat health problems according to the patients' cultures. The medical practitioners' empathy with the cultural beliefs and the values of the patients will facilitate the medical treatment they give to the patients.

In conclusion, it is necessary for the medical practitioners to deepen their knowledge of cross-cultural health communication and to improve their skills to communicate with their patients. Their effective communication with patients will minimize redundant administrative procedures and unnecessary health treatment. They should realize that their medical system is not the only one in the universe. Rather, there are other medical systems beyond their knowledge which might be valid as well, at least in the patients' cultural perspective.

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Bibliography

Brislin, Richard and Tomoko Yoshida. 1994. *Intercultural Communication Training: An Introduction*. Thousand Oaks: Sage.

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- Condon, John and Fathi Yousef. 1985. *An Introduction to Intercultural Communication*. New York: Macmillan.
- Geist, Patricia. 2000. "Communicating Health and Understanding in the Borderlands of Co-Cultures." In Larry A. Samovar and Richard E. Porter, eds. *Intercultural Communication: A Reader*. Ninth Edition. Belmont: Wadsworth, 2000, PP. 34 1-354.
- Hall, Edward T. 1973. *The Silent Language*. Garden City, NY: Anchor Books.
- Hofstede, Geert. 1994. *Culture and Organizations: Intercultural Cooperation and Its Importance for Survival*. London: HarperCollins.
- Littlejohn, Stephen W. 1996. *Theories of Human Communication*. Third Edition. Belmont: Wadsworth.
- Mulyana, Deddy. 1996. "Introduction" to Stewart L. Tubbs and Sylvia Moss. *Human Communication*. Translated and edited by Deddy Mulyana. Bandung: Rosda, 1996, pp. v-xiii.
- Pace, R. Wayne and Don F. Faules. 1998. *Kominunikasi Organisasi: Strategi Meningkatkan Kinerja Perusahaan*. Translated and edited by Deddy Mulyana. Bandung: Rosda.
- Rich, Andrea L. 1974. *Interracial Communication*. New York: Harper & Row.
- Rogers, Everett M. 1995. *Diffusion of Innovations*. Fourth Edition New York: Free Press.
- Samovar, Larry A. Samovar and Richard E. Porter. 1991. *Communication between Cultures*. Belmont: Wadsworth.
- Suartika, Wayan. 2000. "Air Hidup dan Air Mati," *Intisari*, July 2000. p.133.

