Adopting a Critical Intercultural Communication Approach to Understanding Health Professionals' Encounter with Ethnic Minority Patients

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Abstract

Even in the Scandinavian countries, where welfare resources such as education and healthcare are offered wholly or partly free of charge, health disparities between the majority populations and ethnic minority groups challenge the national healthcare systems. The knowledge levels of health professionals and their approach to ethnic minority patients influence the accessibility of healthcare and availability of health prevention resources of ethnic minorities. When adapting healthcare practice to minority patients, healthcare professionals draw on insights from intercultural communication and anthropology. However, within these disciplines such concepts as culture, interculturality, and ethnicity are subjected to contestation due to co-existing, but competing paradigms. This paper demonstrates how healthcare discourses on ethnic minority patients reflect shifting intercultural communication paradigms and advocates the adoption of a critical intercultural communication approach in relation to ethnicity-based health inequality.

Keywords: *intercultural health communication, ethnic minority patients, health disparities, Denmark*

Introduction

Despite their accession to UN resolutions and charters[1] emphasizing the necessity of access to basic healthcare for all citizens, many Western countries experience ethnic minorities' health as a severe challenge to their national healthcare systems. Apparently, deterioration of living conditions in the global South causes high numbers of developing country citizens to leave theirhomes in search of livelihoods in Western countries.This generates a situation in which global inequalities in health are reproduced within the national borders of the Western countries themselves. Among several indicators of the vast health inequalities between rich developed countries and poor developing countries are levels of infant and child mortality and, of course, dramatic differences in life expectancy (CSDH 2008; Marmot 2005). But also *within* countries, health differences are remarkable and directly associated with socioeconomic status. Even within the Scandinavian countries, known for their egalitarian principles regarding basic welfare resources such as education and health, health disparities between the majority population and ethnic minority groups are emerging (Folman and Jørgensen 2006; Villadsen, Mortensen and Andersen 2010; Hemminki 2009; Abebe 2010; Nielsen and Krasnik 2010; Koochek, Montazeri, Johansson, and Sundquist 2007). Such disparities illustrate that, despite historical efforts to build inclusive healthcare systems securing high standards of public health, such systems may fall short when facing immigrant health problems. Commenting on similar health disparity patterns in Sweden, the Netherlands and Belgium, Nielsen and Krasnik conclude that "none of the three countries have been able to intervene with the poorer health status among Turkish and Moroccan migrants" (Nielsen and Krasnik2010: 369). Even though the access to basic healthcare in the Scandinavian countries does not directly depend on economic means, some groups of minority patients may still be understood as marginalized (Dutta 2008: 153) as

their access to health resources are blocked by multiple factors, including factors related to their economic situation. Chief physician of the Clinic of Immigrant Medicine (*Indvandrermedicinskklinik, IMK*) Morten Sodemann depicts the conglomerate of problems facing immigrant patients in a very concrete way:

> "*Often, the patients come here [to IMK] literally carrying a plastic-bag full of problems: letters in Danish that they cannot read, bills they cannot pay, job training they cannot handle. It stresses them to a degree that it reawakens old traumas.*" (Morten Sodemann, chief physician, Clinic of Immigrant Medicine (IMK), in the Danish newspaper Politiken. [author's translation] (Ringkøbing 2009).

Systematic occurrence of inequalities in health in the Scandinavian countries indicates the need of political and structural interventions addressing the poor accessibility of basic healthcare and the lacking availability of health prevention resources found in specific population groups. However, problems of access now appearing as data and information in health statistics are related to daily practices in families, neighborhoods, and in healthcare institutions. Thus, healthcare professionals represent a critical factor regarding the goal of overcoming health problems in the immigrant population. Tasks performed by healthcare professionals (diagnosis, treatment, care, and information/education of patients etc.) form the backbone of every effort to improve ethnic minority health. Thus, the competences, attitudes, skills, and knowledge of these professionals are often addressed in governmental initiatives for improvement of minority health. The DanishNational Board of Health, for example, has played an active role by disseminating research results on ethnic minority health, by providing inspiration through publication of best-practice examples, and by issuing informative booklets and guidelines addressing the specific information needs of health professionals. It is openly recognized that Danish research in ethnic minority health is scarce, sporadic, and somewhat unsystematic in terms of strategy and direction[2], probably due to the fact that, until recently, Denmark has not been seen as a multiethnic society, in which health and health prevention resources are unevenly distributed among different ethnic groups. However, as emphasized by Nørredam and Krasnik, the need for research and knowledge regarding ethnic minority health in Denmark is urgent, not least in health education (Nørredam and Krasnik 2010).

Addressing this need through research, information, and education is not, as this paper intends to illustrate, as straightforward as it may seem. Underlying any attempt to raise the knowledge and competence levels of health professionals and students in health education programs are complex and contested concepts such as ethnicity and culture. The approach taken to these concepts will deeply affect the health messages sent by the knowledge-disseminating institutions to the health professionals and their patients. The purpose of this paper is to examine two sources of information targeting Danish health professionals' needs of information in the area of ethnic minority patients in order to identify different – and changing – conceptualizations of ethnic minority patients based on different approaches to culture and cultural identity. The two sources of information are publications issued by the Danish National Board of Health (*Sundhedsstyrelsen*) and articles on ethnic minority patients published in the journal of the Danish Nursing Union 'The Nurse' (*Sygeplejersken*). The discourse analytic study of texts published by these sources reveals that different and even conflicting approaches to culture and the intercultural encounter between health professionals and ethnic minority patients exist. Therefore, the paradigm of critical intercultural communication theory will be introduced as a way of overcoming the dilemmas inherent in the current approaches to information and education in the area of ethnic minority health.

Methodological considerations – approach, focus, and data

The analytic focus of the research is placed on the statements on health professionals' encounter with ethnic minority patients as they are articulated in the discursive contributions collected in the sample, which consists of 91 articles from 'The Nurse' (*Sygeplejersken*) and 7 publications issued by the National Board of Health. No attempt is made to address more detailed levels of language use or draw any conclusions based on grammatical or syntactic features of the texts. The research approach does not target

micro level linguistic processes in everyday social interaction but identifies with "..approaches […] more concerned with general overarching patterns and aim at a more abstract mapping of the discourses that circulate in society at a particular moment in time or within a specific domain." (Jørgensen and Phillips 2002: 20).

Already in 2000, Alvesson and Kärreman pointed out that the word 'discourse' was used in an – unproductively – wide range of meanings, not least within organizational studies. As can be seen in various introductions to discourse analysis, some strands of discourse analysis insist that a detailed linguistic analysis represents the hallmark of (at least critical) discourse analysis:

> *"In any case, the linguistic character of CDA becomes evident, because in contrast to other approaches of text and discourse analysis (…), CDA strongly relies on linguistic categories. This does not mean, of course, that topics and contents play no role, but the core operationalizations depend on linguistic concepts such as actors, mode, time, tense, argumentation and so on." (Wodak and Meyer 2009: 28).*

Other approaches identify discourse analysis with broader characterizations of discourse framings of certain sets of themes, problems, and developments. Gee, in his introduction to discourse analysiscollects a comprehensive list of phenomena under the 'umbrella term' Discourse (with a capital D), including phenomena which normally are perceived as core research objects of other disciplines (for example intercultural communication or anthropology) (Gee 2001: 38). In an attempt to sharpen discourse analysts' awareness of the approach taken, Alvesson and Kärreman introduce a typology based on two distinctions: 1) discourse determination vs.discourse autonomy 2)long-range interest vs. close-range interest. Discourse analytic studies tend, according to Alvesson and Kärreman, to differ in terms of their view of the relationship between discourse and other aspects of social reality, for example the aspect of meaning. Some perceive meaning and other aspects of social reality as entirely discursively constituted ("discourse determination") whereas others see discourse merely as an aspect of social reality ("discourse autonomy"). Furthermore, discourse analytic studies tend to either limit the scope to concrete communicative events and processes (close-range interest) or have a broader, more comprehensive scope (long-range interest). Embracing this typology, this study identifies itself as a long-range interested discourse-analytic study. It also accepts the view that discourse, in combination with other factors, such as economic and political factors, has determining effects on social reality in the sense that dominating discourses frame perceptions as well as verbal and non-verbal action. Exactly this interplay between discourse and its social effects forms the core interest of the study. Focus on overarching discursive patterns and their interplay with social and political implications and effects enables understandings of discourse-historical trajectories such as, for example, found in Zinck Petersen's work on historical changes in the discursive construction of the patient in Danish healthcare (Zinck Pedersen 2008). Ultimately, such interests in broader historical discourse changes and their complex interrelatedness with social and political dynamics (as opposed to 'close-range' linguistic investigations) owe much to Foucault's own way of approaching discourse as an entry into analysis of historical processes. Such a stance emerges in the following statement from a 1977 interview with Fontana and Pasquino:

> *"The problem is at once to distinguish among events, to differentiate the networks and levels to which they belong, and to reconstitute the lines along which they are connected and engender one another. From this follows a refusal of analyses couched in terms of the symbolic field or the domain of signifying structures, and a recourse to analyses in terms of the genealogy of relations of force, strategic developments, and tactics. Here I believe one's point of reference should not be the great model of language (langue) and signs, but to that of war and battle". (Foucault 1980: 114).*

In the investigation of the discursive construction of ethnic minority patients, culture, and cultural difference, the conclusions are based on a discourse analytic investigation of a sample consisting of all articles on ethnic minority patients published in the Danish nursing journal "The Nurse" (*Sygeplejersken*) from 2000 to 2008 and on all publications addressing ethnic minority health published by the National Board of Health (*Sundhedsstyrelsen*) within the same period. The sample reflects an interest in inquiring into the officially established discourse on ethnic minority health and ethnic minority patients in the

Danish healthcare sector. Furthermore, by collecting a sample covering a time period rather than a specific point in time, the researchers are able to detect changes and developments in problematizations, i.e. the discursive-construction of an 'issue' demanding presentation, analysis, reflection, and discussion among health professionals. The term 'officially established discourse' indicates that this research takes no interest in uncovering health professionals' personal discursive framings of ethnic minority patients and related topics as they are enacted in everyday conversations at, for example, hospital wards. The project had no particular interest in capturing health professionals' everyday conversations around ethnic minority patient topics. The research only includes contributions that through publication are made accessible to the entire community of health professionals and, in principle, to anybody with an interest in the topic. Of course, any author addressing a public forum selects a mode of articulation differing significantly from the mode that the same person would have chosen in an informal context (Gee 2001). However, the research interest was not to go beyond the discursive surface to some unconscious layer where the individual health professional might have expressed a personal attitude deviating from institutional and professional norms. On the contrary, the research focused on identifying such norms, i.e. the norms operating in the construction of discursive contributions produced by professionals, conscious of the professional perspective of themselves and their audience.

The decision to base the conclusions entirely on written material may be criticized. One could argue that an investigation based on orally produced data (for example interviews) would have generated a truer and more authentic depiction of health professionals' discourse on culture. Articles in a journal may not be seen as reflecting the everyday conversations at the hospital wards and therefore not 'the discourse'. However, it is important to be aware of the interdependence of data sample and research interest. What can be captured in interview data will be a limited number of health professionals' discursive framings, framings which in all probability are influenced by the concrete interview situation and the micro-level processes created in the concrete interaction between interviewers and interviewees. Revealing in this regard are Strunck and Lassen's reflections on a focus group interview with three health professionals on their experiences of providing healthcare to ethnic minority patients. Strunck and Lassen realize that, despite the fact that they evidently interact with the same three individuals during the entire interview, the interviewees oscillate between quite different discursive roles:

> *"However, the overall impression is that the health professionals we interviewed changed identity a number of times while discussing the issue of foreign ethnic patients, shifting between being cultural relativists, professional nursing staff, frustrated and overworked nurses and, more often than not, simply human beings." [my emphasis] (Strunck and Lassen, forthcoming).*

Such oscillations between discursive positions are in themselves highly interesting and reveal, among other things, the difficulty of maintaining a consistent, professional approach to issues which may involve the interviewees' own personal and cultural identities. However, this observation also underlines the necessity of drawing on other types of data if the researcher intends to depict macro-level patterns in the discursive framings of the challenges that ethnic minority patients present to health workers as a professional community.

Changing discourses on ethnic minority patients in the Danish healthcare sector in the period from 2000 to 2008

Undoubtedly, the increasing number of ethnic minority patients in the Danish healthcare system during the last two decades represented a major challenge to the Danish healthcare sector, and not least to Danish healthcare professionals (Michaelsen et al. 2004; Dansk Sygeplejeråd 2006). An indication of this is the increasing number of guidelines and informative publications published by the National Board of Health, especially from 2005 and onwards. In 2005, the Danish Nursing Union and its professional journal initiated a survey study among Danish nurses, which very convincingly demonstrated that a majority of

Danish nurses perceived ethnic minority patients as an extra burden. In the aftermath of the quite heated debates following the publication of the survey results, several leaflets and reports were issued by the National Board of Health. Ethnic minority health became a topic of political interest as well as the competencies of health professionals in relation to this area.

Early contributions to the discussion of ethnic minorities appearing in "The Nurse" pinpoint that culture influences health. The cultural values of immigrant families are perceived to have detrimental health effects, not least for young children. Children in immigrant families are depicted as under-stimulated, linguistically, emotionally, intellectually and physically. Even relatively well-educated minority parents seem to lack understanding of children's needs and their own duties in securing a healthy development of the individual child. 'Culture' is made responsible for the many evils haunting the lives of minority families, especially the frustrated and stressed-out mothers: dependence on and faith in family networks rather than in professional advice, numerous child births, unengaged and/or mentally destabilized fathers, unruly children with little respect for their mothers, and even unfounded ideas about the detrimental health effects of the cold Danish climate. Furthermore, culture is believed to cause communication breakdowns, because minority patients are seen as unable to comprehend the health messages sent by the health professionals. In most contributions, such breakdowns are not constructed as unsuccessful intercultural communication situations but rather as clashes between culture (and culture-bound worldviews) and professionalism. In other words, what the health professionals present as desirable parenting behavior to the minority families is not seen as particularly culture-specific but simply as the healthy way to raise children (for example). Information and advice given to fellow nurses in the contributions emphasize culture-related differences between Danish patients and minority patients. The underlying problem addressed in such contributions seems to be that Danish nurses may feel insecurity regarding these very different patient groups and may expect minority patients to be similar to Danish patients. Thus, cultural differences must be pointed out and explained (under such headlines as for example "Moslem patients" (Barkani 2003)).

In later contributions (in the period from 2005 to 2006), focus seems to be on pragmatic and flexible solutions. It is recognized that cultural differences exist, and that health professionals have legitimate professional concerns because of culture-related and communicative obstacles to effective professional treatment and care. However, reasonable trade-offs must be found between insisting on maintaining healthcare procedures 'the Danish way' and respecting every culture-specific expectation. The underlying assumption that minority patients are indeed significantly culturally different from ethnic Danish patients is not questioned. What is articulated, though, is a more pragmatic attitude to the priority given to culturally different needs and expectations. Even though nurses perceive minority patients' reactions asbeing more emotional than the reactions of Danish patients,they just have to uphold their professional perspectives and prioritizations.This is explained by a nurse based on her experience of minority patients in the emergency room of a large Danish hospital:

> "In emergency situations, I sometimes experienced that especially family members would get very upset about the fact that their family members could not get treatment right away. I had to explain to them that they weren't ignored but that I had to prioritize. It was difficult to cope with these situations because these people's reaction totally differed from the reactions that we are used to." [author's translation] (Kjærgaard 2006a).

'Professionalism first, culture second' seems to be the dominating understanding asanother nurse responsible for prioritizing patients in an emergency room states:

> "Our goal is to offer the same good treatment and care to all – irrespective of ethnic affiliation. I use to say that we must work problem-oriented, not based on our attitudes. But, of course, this does not mean that we ignore the importance that culture has in relation to the patient's perception of the disease" [author's translation] (Kjærgaard 2006b).

In the most recently published articles, one increasingly finds contributions that begin to question the underlying assumption of fundamental cultural differences between the various minority patient groups and the health professionalsmainly belonging to the ethnic majority. It is increasingly emphasized that

each patient must be met as an individual, not as a representative of a specific ethnic group. For example, in the newsletter '*Synergi*' (2007), the leader of the Professional Society for Transcultural Healthcare, Marianne Østerskov, states that:

> "*Our intention is to draw attention to the fact that ethnic minorities must be met as individuals and with curiosity and respect.* "[author's translation] (Thomsen 2007)

Furthermore, she thinks that there is a tendency to "put people with a non-Danish background into a box because of their ethnicity" (Thomsen 2007).

This approach is supported by the guidelines in the publication of the National Board of Health"Health Professionals in a Multicultural World" (Breinholdt 2007). The booklet does not present health professionals with concrete guidelines on how to 'handle' minority patients, not even in the form of pragmatic solutions. Instead it seeks to instigate reflection and discussion through information, illustrative anecdotes, and a 'light' introduction to culture theory. Evidently, healthcare 'in a multicultural world' involves a wide range of ambiguous situations, in which the health professional must be able to trust her own judgment and adapt her professional knowledge to the concrete case. What is signaled is: the *individual* first, then professionalism adapted to the individual's specific needs. Some of these needs may be connected to the individual's cultural background, but it is important not to anticipate cultural needs based on a stereotypical concept of the specific ethnic group. The ideological underpinning of this approach is to be found in a new understanding of the culture concept – the so called 'heterogeneous' culture concept. The heterogeneous culture concept depicts culture as anti-essentialist and dynamic and emphasizes the elusive and constructed character of cultural identities. When encountering patients, the nurse never knows how the individual relates to his/her own cultural and ethnic background. Thus, the health professional should first and foremost inquire into the patient's medical condition and then, as a supplement to the medical anamnesis, inquire into culture-based preferences in a frank, non-judgmental, and professional tone. The health professional is encouraged to perform a form of 'mini-ethnographic' inquiry and in relation to the patient's cultural identity pose the following questions:

> "*How is your daily diet? [instead of assuming a specific 'ethnic diet']; What do you normally eat at home? Do you want us to make special arrangements concerning your diet? Are you religious? In that case, which religion? Does the religion influence your concept of your disease, treatment, and care? Do you mind whether it is a male or a female health professional who will examine you and provide personal care? What does your family think of your disease? What is your disease called in your own language? How do you think that your disease would be cured by a doctor in your home country?*" [author's translation] (Breinholdt 2007: 40).

Of course, these questions may themselves be seen as revealing a slightly stereotypical way of thinking of cultural identities (having a specific cultural identity implies specific food habits, religion, specific concepts of gender roles, specific norms concerning exposure of the body in non-private contexts etc.). Still, the very act of questioning instead of simply taking certain combinations of ideas, norms, and preferences bundled as cultural identities for granted represents an important change of attitude. The method or 'technique' recommended as a consequence of adopting a 'heterogeneous' culture concept is the ethnographic inquiry combined with an unprejudiced attitude to the individual patient:

> "*If we use the heterogeneous culture concept, we can conclude that the assumption that one can suffer from a serious loss of blood because of a blood test, is more widespread among women who originally come from Turkey than among women with a Danish cultural background. Thus, this research can inspire the questions that one may ask, and shows one of the many ideas that we as human beings have concerning our body and health*"[author's translation] (Breinholdt 2007: 25).

An unbiased mode of approaching the ethnic minority patient that is sensitive to variations in the individual's relation to his/her cultural identity is promoted in nursing education as well. This becomes

evident in the following review of a textbook for nursing education which is highly praised for its usefulness both in nursing education and in nursing practice. As in "Health professionals in a Multicultural World", readers are particularly warned against over-emphasizing cultural difference and against interpreting too many phenomena as 'cultural':

> *"Magelssen's [the author of the textbook] basic argument is that people often misinterpret what they see, as being culture. One tends to identify the concrete actions of specific individuals (clothing, food etc.) with 'culture'. Culture is a model through which we perceive the world, rather than something we actually see. What we perceive is based on our knowledge, values, patterns of action and rules. But what people do – what we see – are articulations of culture. In other words, the relationship between culture and cultural articulations is like the relationship between traffic rules and traffic. But what people do is not necessarily culture." [author's translation](Ludvigsen 2008).[3]*

Based on the heterogeneous, but comprehensive sample of written material published in "The Nurse" (*Sygeplejersken*) by the Nursing Union and the National Board of Health in the period from 2000-2008, it is possible to identify systematically different discursive framings of the relationship between culture, ethnic minority health, and healthcare. The first period is characterized by the need to create an awareness of the new problems encountering health professionals in view of increasing immigration. There are generally no reservations regarding explaining 'deviant' health beliefs and behaviors as culture-related or regarding framing communication difficulties caused by culturally different worldviews in ethnic minority populations. TheCatinet survey (Dansk Sygeplejeråd 2006) and not least the presentation of its results seemed, however, to serve as a kind of 'wake-up call' in several respects. Some perceived the survey results as a candid description of reality, while others saw the entire maneuver (both the survey itself and the presentation of it) as a legitimation of immigrant-hostile sentiments and policies. Tensions at the national political level in the period around tightening of immigration policies played a role in the debate and were directly referred to as the backdrop of the survey and media presentation of the results. Such debates took place on the online debate forum of the nursing union. What became important in the period following the Catinet survey was the identification and presentation of 'success stories', i.e. well-functioning initiatives and pragmatic solutions to problems which generally caused frustrations among health professionals. The double-sided strategy of, on the one hand, an uncensored account of the problems and, on the other, presentation of best practice examples seemed, according to chief editor of "The Nurse" SigurdNissen-Petersen, to be the most appropriate answer to a set of concerns that were so massively articulated by a majority of survey respondents that they could not be ignored. However, the very outspoken critique of the editorial line in this case did not only address the discursive framing itself ("Immigrants are a problem in Danish hospitals") but also the appropriateness of such framings. As one of the critical contributions to the online debate pointed out, it may be the case that nurses feel overwhelmed by the complexity of cultural, communicative, and medical problems represented by minority patients, but the line chosen by the editor and the journalists was likely to exacerbate the conflicts generated by such problems. In other words, some of the critical contributions did not deny the problems but questioned the effectiveness of an immigrant-critical discourse in remedying the situation. That a connection was made between discourse, general political climate, and the practical reality at hospital wards may have helped pave the way for the far more cautious and sensitive discursive approach of the 2007 and 2008 contributions. In guidelines and textbooks, the so-called heterogeneous culture concept is promoted, and the main disciplinary inspiration comes from anthropology and interpretive intercultural communication (for example Jensen (2006)). The ideal encounter between immigrant patient and health professionals is characterized by openness and curiosity, and the health professional focuses on the individual patient instead of focusing on the patient's cultural background. This form of culture-sensitive and simultaneously individually customized healthcare is enabled through the practice of ethnographic inquiry as described above.

The operationalization of the 'heterogeneous culture concept' and an interpretive intercultural communication approach in terms of the health professional as a (mini) ethnographer and the (ethnic minority) patient as an informant on his/her *personal* relation to a specific cultural universe represents a new ideal model of the intercultural encounter in Danish healthcare.

Discussion

In contributions adopting a heterogeneous culture concept and an interpretive approach to intercultural communication, it is frequently emphasized that one cannot, on beforehand, provide the health professional with a body of culture-specific knowledge or a set of guidelines applying to specific ethnic groups. What *can* be done is to provide the health professional with methodological instruments enabling him/her to gather the relevant information herself (as 'mini-ethnographer'). Such instruments include the ability of the health professional to reflect critically on own assumptions and question how such assumptions may play into the dynamics of the encounter with minority patients. The unwillingness to categorize and label ethnic minority patients as representatives of specific groups seems, however, to work against the widespread demands for knowledge and guidelines required by, for example, healthcare practitioners. Such demands may be understood as articulations of the kind of functionalist and essentialist thinking that often forms the point of departure for the novice intercultural communication student (Halualani 2011, Blasco 2009). Not least the popularity of the so called functionalistic approach to intercultural communication has disturbed many interpretative intercultural communication scholars. This approach, drawing on such influential scholars as GeertHofstede and Edward T. Hall, has led to widespread classification of individuals based on their ethnic and cultural identity. One serious obstacle to convincing both students and professional practitioners to take another approach is a pedagogical one: it is simply much more difficult to explain an approach to culture and intercultural communication based on the contention that culture is unpredictable, dynamic and infinitely complex. As stated by Halualani (2011), checklist approaches to culture will – at least on a short term basis - produce more satisfied learners than approaches systematically questioning the students' view of themselves and the culturally others. Obviously, the new guidelines of the National Board of Health ("Health Professionals in a Multicultural World") explicitly have the ambition to counter functionalist approaches and promote the more nuanced and complex approach epitomized in the heterogeneous culture concept.

Demands for more knowledge may, however, reflect that health practitioners do, in fact, experience the needs of (some) ethnic minority patients as markedly more complex than the needs of majority patients. Consider, for example, the following characterization of a seemingly large patient group:

> *"Clearly, we see a group of immigrant patients who have become permanent patients with highly complicated symptom patterns, uncharacteristic pain experience, PTSD, symptoms of severe anxiety, overweight complicated by language problems, diabetes, poor social networks and lacking understanding of the human body. Typically, these patients are thrown between primary care, medical specialists and different hospital wards without any coordination or attempt of reaching a final diagnosis. These patients are, to the same extent, thrown between caseworkers in the social system in the municipalities." (Sodemann, Svabo, Nielsen, and Korsholm 2010: 48-49)*

Interestingly, the most effective way to deal with this complex problem is *not* to think of a member of this patient group as just another individual patient coming in contact with the Danish healthcare system. On the contrary, in order to address the entire conglomerate of medical and social problems, an interdisciplinary 'Clinic of immigrant medicine' (*Indvandrermedicinskklinik*) has been set up, and close cooperation with a health clinic in a neighboring residential area, well-known for its numerous immigrant residents, has been established. Furthermore, it seems to be the precise categorization of these patients as having a specific social and cultural identity that eventually increases their chance of correct diagnosis and treatment (Sodemann, Svabo, Nielsen, and Korsholm 2010).

Such observations seem to put intercultural communication research in health in a serious dilemma. On the one hand, health professionals are encouraged to engage in more reflective, sensitive, analytic, and individualized approaches and practices regarding their ethnic minority patients' cultural identities. On the other hand, knowledge of group characteristics and recognition of collective social and cultural identities seem to enable effective treatment and care. The purpose here, however, is not to criticize the healthcare sector for inconsistency in its approach to culture and ethnic minority patients. In other words, the purpose is not to pass judgment on the legitimacy of the approaches. Rather, the purpose is to reflect critically on the interplay between intercultural communication theory and its adoption in health

communication and education. As intercultural communication scholars, we may, for example, ask ourselves if the virtues of openness, curiosity, and (self)reflection provide the health professional with a sufficient epistemological, ethical, and practical background to confront harsh social realities such as the social and economic situation of the immigrant patient group described above. Or if we must realize that the sensitive approach to the individual only makes sense if it is based on insights in social, political, and historical conditions, involving, among other things, recognition of the importance of collective identities.In order to at least address such questions, a more comprehensive theoretical foundation to intercultural communication must be adopted.

The Critical Turn in Intercultural Communication Research

In intercultural communication research, there is now a general consensus that a new paradigm – critical intercultural communication – can be identified. Until now, the most conspicuous manifestation of the existence of such a new paradigm is the publication in 2010 of "Handbook of Critical Intercultural Communication", edited by Nakayama and Halualani. However, the emergence of a new and critical paradigm had been announced in earlier contributions as well, for example in Halualani, Mendoza, and Drzewiecka 2009 and even in a textbook meant for intercultural communication teaching (Martin and Nakayama 2007).The critical intercultural communication paradigm is conceived by the scholars adhering to it as distinct from the paradigm of interpretive research, which theynevertheless recognize as providing valuable insights on specific aspects of intercultural contact. Martin and Nakayama even advocate dialectic relations between and across paradigms (Martin and Nakayama 2010). The main difference between the interpretive and the critical paradigm is the propensity of the latter toinclude macro perspectivessuch as historical, political, and social factors in research on intercultural contact(Halualani, Mendoza, and Drzewiecka 2009). This move does not, however,lead to sweeping generalizations ofnational cultures(as is often seen in functionalist intercultural communication research) but rather to a critique of the social, historical, political, and discursive structures forming the conditions of contemporary intercultural contact. Consequently, critical intercultural communication scholars disagree with interpretive scholars' micro-oriented perspective, i.e. their focus on local, interpersonal encounters,which, to the critical scholars, amounts to a neglect of socio-political and historical constituents of such encounters (Mendoza, Halualani, and Drzewiecka 2002: 314).

Regarding the Scandinavian (or even Nordic) intercultural communication research environments, one could argue that the perspective on mainstream intercultural communication theory has always been critical – or at least skeptical. Tange (2009) even states that "Nordic researchers often define their work in opposition to the hegemony of the American functionalist paradigm, using the theoretical positions of semiotics, social constructionism, critical hermeneutics and poststructuralism to challenge the notions of absolute cultural values and differences" (Tange 2009, 234). The bulk of Danish intercultural communication research has, for example, been produced in direct opposition to mainstream international intercultural communication theory and in an attempt to pave the way for a more nuanced, sensitive, and (self) reflective thinking about intercultural relations (Hjort, Løngreen, and Søderberg 1993; Askehave and Norlyk 2006, Blasco 2009). Thus, Nordic intercultural communication research has contributed to functionalism critique and articulation of (mostly) interpretive alternatives (Dahl, Jensen, and Nynäs 2006). Such alternative approaches are generally applied in Scandinavian intercultural communication studies in education (e.g. Larzén-Östermark 2008) as well as in philosophical approaches to ICC (Nordby2008).Intercultural communication studies on workplace diversity have found social psychological research on, for example, work values and organizational hierarchies valuable, especially if such research is combined with awareness of the importance of language competence and differences in communicative styles (Allwood, Lindström, Börjesson, Edebäck, Myhre, Voionmaa and Öhmann 2007; Berbuyk, Allwood, and Edebäck 2005). From the perspective of ethnography of communication, Swedish researchers have, however, commented critically on the leverage of mainstream intercultural communication research (Hofstede) compared to detailed studies of social interactions: "..it might be more fruitful to study intercultural communication from the point of view of activities and social interactions among the individual agents instead of simply contrasting stereotypical behaviours."(Allwood and Jokinen 2010).

Despite the fact that Nynäs (2008a, 2008b) addresses one of the most popular topics in intercultural communication research, the life situation of expatriates (or 'global workers'), his approach departs markedly from mainstream research as he from a theoretical perspective combining deep-hermeneutics, mobility studies, human geography, and psychology analyses global workers' precarious relations to the foreign spatial and cultural environments. By pointing to the essential relation between the physical and sociocultural environment and the inner space, i.e. the individual's sense of self, Nynäs draws attention to the serious implications of endangering or distorting this relation through constant *dis*placement, i.e. work-related transfer from one place to the other. His empirical research demonstrates how such distortions lead to global workers losing their sense of self and thus their sense of themselves as moral subjects bearing responsibilities for the physical as well as social environments in which they are placed. By uncoveringfundamentally dehumanizing processes involved in the lifestyle of an 'international expert' and their contingency on neoliberal, globalized economic and social structures, this research articulates a severe, but nuanced criticism of these structures and the conditions produced by them.Thereby, it connects itself more clearly to the emergent strand of critical intercultural communication research than the bulk of, for example, Danish intercultural communication research, which has limited its scope to a critical reception of mainstream functionalist research.The term 'critical' is to be understood in a more comprehensive way than just critical of established paradigms. The critique of critical intercultural communication research is, first and foremost, a social and political critique, i.e. a critique addressing the historical, political, institutional, and social constituents of intercultural encounters.

Scandinavian intercultural communication research as well as interpretive strands of American and Europeanintercultural communication research (e.g. Carbaugh and Berry 2001) has done much to deconstruct simplified understandings based on primarily nation-specific categories by consequently emphasizing the specificity of the situation and the particularity of the individual(s) involved. These research strands maintain that cultureand culturally congruent or divergent perspectives are constructed socially and discursively in concrete interpersonal encounters. Consequently, such strands detach the perception and description of individuals from the bonds of predefined cultural identities. Critical intercultural communication scholars agree that such steps are helpful but maintain that they do not free the researcher of the obligation of understanding the dynamics of construction of collective identities embedded incomplex and ever-changing power contexts. Critical intercultural communication scholars tend to view all ascriptions and avowals of identities as identity-political since no identity exists as naturally given without being constructed and enacted by concrete human beings (Mendoza, Halualani, Drzewiecka 2002:322).

That a critical intercultural communication approach in fact represents a paradigmatic shift is underlined by the fact that constituting concepts of intercultural communication theory:culture, communication and cultural identity are subjected to inquiry and reformulation (Halualani and Nakayama 2010; Moon 2010). The notion that the phenomenon of culture is intimately related to the need of human beings to experience their world as meaningful has probably never been articulated with larger impact that in Geertz' famous dictum: "man is an animal suspended in webs of significance that he himself has spun, [and] I take culture to be those webs" (Geertz 1973: 5).Understandings of the culture concept in coherence with Geertz' definition led intercultural communication scholars to conceptualize intercultural communication situations as contact between individuals who happened to draw on divergent universes of meaning and thereby produced mutually unintelligible utterances, even in cases where a shared lingua franca was used. A wide range of studies provided evidence that even the tiniest verbal or nonverbal move in such encounters maygenerate unintended interpretations because of the interlocutors' propensity to ascribe meaning to every detail of communication (e. g. Gumperz 1982;Carbaugh 2005). Particularly contributions drawing on the strong British sociolinguistic tradition convincingly made the point that interethnic communicative encounters play a major role in the production of social identities of members of various ethnic groups and thereby in the distribution of resources in multiethnic societies, including access to jobs, education, and health services. Still, however, according to critical intercultural communication scholars, more attention should be paid to political, institutional, and not least historical factors in the production of social and cultural identities:

> "…past intercultural communication research has concentrated on the co-construction of identity through social interaction (the interdependent nature of avowal and ascription processes) at the expense of larger politicized forms of social ascription (e.g.,

governmental/state categories of identity, historical myths about who groups are, a group's constructions of authenticity), forms that may further explain the enacted communicative practices and place them in a dialogic context between structural constructions of identity and re-created group identities by cultural members themselves." (Mendoza, Halualani, and Drzewiecka 2002: 314).

A focus on macro-level structures and on the influence of such structures on concrete social and cultural practices will inevitably lead to a dismantling of some of the core assumptions of both functionalistic and interpretive intercultural communication research, i.e. the assumption of the intercultural communication encounter as a more or less neutral stage at which interlocutors happen to have a limited access to each other's frames of understanding. Instead, participants in intercultural communication must always be seen as already positioned, as vested with particular interests, struggling to have their own meanings recognized as the frame of reference of the conversation. Not least the perception of communicative meanings as non-fixed, fluid, and contested calls for an approach to communication surpassing traditional communication models. Such an approach is found in Stuart Hall's encoding-decoding model, according to which meaning interpretations are seen as articulations in their own right. Hall emphasizes that such articulations are producedby actors who hold different positions in relation to social, political, and cultural hierarchies (Hall 1992;Halualani and Nakayama 2010).

Concluding comments – and a remaining question

Considering the interplay between intercultural communication paradigms and their uptake in health communication, it is evident that the knowledge gap in the Danish healthcare sector generated by a sudden increase in immigrant patients sparked intercultural communication researchers' interest in health communication and – vice versa – the interest of health professionals in intercultural communication. The mutual interest in intercultural communication in healthcare settings has provided a fertile ground for knowledge exchange, for example in the form of continuing education programs for health professionals. As argued above, the strong tradition for interpretive intercultural communication research may have had some impact on the form of intercultural communication research taken up in the communities of health professionals. The effects of the dominating position of interpretive intercultural communication research has led to an emphasis on the individual patient, an adaptive and reflective approach to culture and a dedicated attempt to avoid collective representations or ethnic labeling when addressing immigrant patients in discourse or practice. However, the emergence of a socially stigmatized immigrant group with similar interrelated medical symptoms has generated a need for solutions addressing a specific identity group.

In order to maintain its relevance to health communication, intercultural communication research must address the historical, structural, political and institutional conditions underlying the emergence of such patient groups. Attention must be paid to a wide range of different factors, including factors fostering global migration and markedly uneven distribution of global resources. Concerning health and health prevention understood as such resources, it makes a major difference whether health professionals adopt the now dominant tendency in western healthcare institutions to emphasize the individual's own responsibility in maintaining these resources or recognize the importance of structural, institutional, and political factors for the production of disparities in health. The establishment of institutions targeting immigrants' health problems seems to reflect such a recognition. The remaining question, however, is one specifically suited for critical intercultural communication research: the WHY question. As Starosta and Chen point out, questions in need of imminent answers address the structural constituents of cultural and social phenomena: "What is it that presents us with particular cultural practices?" (Starosta and Chen 2003: 15). In the case of ethnic minority patients in Denmark, this approach leads to a foregrounding of such questions as why it hasbecome necessary to establish clinics specifically addressing immigrant health problems in a highly developed welfare state where everybody has the same right to enjoy a healthy life?

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[1]Among others: WHO's resolution "Health for All by the year 2000" (1977); "Ottawa Charter for Health Promotion"(1986); "Bangkok Charter for Health Promotion in a Globalized World"(2005). (Porter 2006).

[2]"In Denmark, research has been characterized by few and limited research activities despite an increasing demand for systematized knowledge and education among the health professionals at the Danish hospitals and among students of medicine and public health. Furthermore, there is a vast interest in these problems among health planners, administrators, and politicians, who need a better basis for decision making. Many problems are taken up in the media and in political discussions, but the documentation of their nature, incidence and causes – and not least of their solutions - is scarce. Consequently, debate and decision-making are often based on guesswork instead of knowledge and documentation."[author's translation] (Nørredam and Krasnik 2010: 83).

[3]Ragnhild Magelssen(2008). "Det er nok noget kulturelt. Kultursensitivitet – om at finne likheterne i forskjellene". Akribe.