*Rev. sci. tech. Off. int. Epiz.*, 2009, **28** (2), 635-647

# Essential education in communication skills and cultural sensitivities for global public health in an evolving veterinary world

S.M. Kurtz [1] & C.L. Adams [2]

(1) Washington State University College of Veterinary Medicine, P.O. Box 647010, Washington State University, Pullman, WA 99164-7010, United States of America, and the University of Calgary, Professor Emerita
(2) University of Calgary, Faculty of Veterinary Medicine

**Summary**
In the practise of veterinary medicine and global public health, communication skill is as critical as clinical reasoning and an extensive knowledge base. Effective communication skills and cross-cultural sensitivity are essential across the board for interdisciplinary, international, and local veterinary medicine. This paper offers an evidence-based, three-part framework for developing and sustaining curricula that enhance communication skills and cross-cultural sensitivity so that students are better prepared to practise veterinary medicine in an evolving world. These curricula may well also serve as a conduit for encouraging more veterinary graduates to choose global public health as a career path.

**Keywords**
Communication – Culture – Curriculum – Global animal health – One health – Relationship-centred care – Veterinary medical education.

## Introduction

The purpose of this paper is to define the communication and cultural education that all veterinarians should receive during their veterinary degree training. This paper will not cover the full scope of communication training that veterinary specialists in global public health would require. Rather it provides a framework for thinking about and planning communication curricula so that all veterinary students have the practical understandings, skills and capacities they will need to communicate about global animal health and to become effective communicators within this area of veterinary service. In the process of learning to apply communication skills and capacities to the issues and problems associated with global public health in the 21st Century more students may be attracted to choosing this area as a career path.

We use the term 'global public health' throughout this paper to refer to animal health and well-being, the effects of animal health on human health, and the integration of the two. The work of global public health is cross-cultural in terms of national, ethnic or religious differences and the differences that exist across disciplinary divides and within veterinary medicine itself. Here 'cultural sensitivity' refers to the communication skills and capacities that enable veterinarians to coordinate their work across each of these potential cultural divides. In the way that we are defining it, cultural sensitivity also embraces the gender issues that are prevalent everywhere in health care.

International collaboration is increasingly essential to the health and well-being of all of us on the globe: human beings, animals, and other living things alike. That makes communication a primary tool in the work of global public health in our current and evolving veterinary world. At the

most elemental level of this work, communication skills are a tool for exchanging information accurately and efficiently. These skills are also the means for developing the relationships that are so critical to international work and public health. Cultural sensitivities rely on the ongoing development of communication skills and a host of capacities. The latter includes, for example, self-awareness, integrity, compassion, etc. Attending to both skills and capacities is important. Without preparation and development of the 'inner ground' of intentions and capacities, the masterful use of communication skills becomes manipulation. On the other hand, the best of intentions and the most well-developed capacities are essentially useless if we do not have the communication skills to demonstrate or apply them effectively in practice.

The time is right, whether we are developing communication and cultural skills curricula or re-evaluating how we teach global public health, to consider the questions addressed in this paper:

– What role do communication skills and cultural sensitivity play in global public health in veterinary medicine? What do we need to teach about communication and cultural sensitivity?

– How do we go about this kind of teaching and learning? What are the evidence-based strategies and approaches for enhancing communication and cultural competencies in veterinary education and practice?

– In addition to identifying contents and methods for the communication curriculum, what else is needed to set up effective communication curricula related to global public health?

The concepts and strategies in this article emerge from the research literature on communication in health care and what it takes to teach communication skills and capacities. We bring considerable experience to this work, including extensive communication teaching, curriculum and policy development, and research in human and veterinary medicine as well as other disciplines. Our combined 45 years of experience includes interdisciplinary as well as cross-cultural and international development work in Africa, Australia, Europe, the Middle East, North America, South America, and Southeast Asia.

# The role of communication – Deciding what to teach

When putting together a communication curriculum, it is common to want prescriptions or directives about content and method. These are important elements. However, we prefer to start with how we conceptualise the role of communication in global public health, because how we think has so much influence on what we do. It is useful to organise this discussion about how to conceptualise veterinary communication around:

– the evidence-based objectives and health care outcomes that communication impacts

– domains of communication that are relevant to veterinary medicine

– the types of communication skills we use in every interaction

– the paradigms and first principles that help determine what to teach regarding communication in veterinary medicine in general and in global public health in particular.

The conceptual framework becomes a map for developing coherent and focused communication curricula and it helps define how communication and cultural sensitivity will move the global public health agenda forward. In considering the needed communication skills in the arena of global public health it is critical to recognise that most global health issues involve interactions between several different cultures. This requires that we become acutely sensitive to differences in how individuals communicate within their own culture and outside of it.

# Objectives and outcomes

An extensive body of research conducted over the last 40 years in human medicine shows that the use of specific communication skills positively influences a number of significant objectives and health outcomes, including:

– increased accuracy, efficiency, and supportiveness

– improved relationships characterised by trust and partnership

– better understanding and recall

– increased adherence and follow-through with treatment regimes and management plans

– better coordination of care

– improved health outcomes (physiological and psychological)

– increased patient safety and decreased risk

– reduced costs

– reduced conflicts, complaints, and malpractice suits

– greater satisfaction for both patient and clinician (see literature reviews in 15 and 19).

While research regarding communication in veterinary medicine is just getting underway it is clear that these

objectives and outcomes are as important in veterinary medicine as they are in human medicine.

Much of the communication research in human medicine has focused on physician–patient interaction. More recently, the veterinary literature has started to report research that describes what is taking place in veterinary–client–patient interactions (6, 7, 17, 18). In both disciplines, researchers are beginning to focus on interactions between clinical colleagues and health care teams. The objectives and outcomes and the particular communication skills through which they are achieved also appear to have considerable relevance for communicating between cultures in the global public health context. The point is that developing particular communication skills and being able to apply them in practice at a professional level of competence is important anywhere in health care where there is interaction between human beings and where the objectives and outcomes above are part of the equation.

## Communication domains

Box 1 delineates the full set of domains that communication influences in veterinary and human medicine. Along with the objectives and outcomes we are aiming for, these domains offer a way to organise communication curricula and suggest ways to integrate it with other parts of the veterinary medical curriculum. Consider how well the domains relate to the interests of global public health.

Most communication programmes begin by focusing primarily on the communication skills and capacities needed in veterinary–client interaction (domain 1) with a significant secondary focus on domains 2, 3 and parts of 8. This focus is logical, because these are by far the best-researched domains and/or the most obvious place to start in terms of perceived relevance and learner readiness or interest. Communication programmes and sometimes other clinically oriented courses or electives address domains 4, 5, 6, and 7. Specialist training will be necessary to deepen some of these domains. For example, those who are making a career of certain aspects of public health (global or otherwise) will need to learn more about effective public speaking, i.e. learning to deliver complex information succinctly to policy-makers, speaking through television and newspaper reporters, etc.

The domains in Box 1 represent the areas of communication that we need to teach for global public health. The definition of global health used by the Institute of Medicine in the United States of America (USA) indicates that solutions to global health are best addressed by cooperative actions and solutions (13). In addition, the

**Box 1**
**Domains of communication in veterinary medicine**

1. **Veterinarian–client interaction**
   - communicating with clients (accuracy, efficiency, relational competence; process and content skills on C-G Guides)
   - communicating with family members, significant others
   - special needs clients (elderly, young, challenged, low literacy)
   - specific contexts, types of practice
   - enhancing client's ability to communicate with clinicians, with 'the system'
2. **Communication issues**
   - culture
   - ethics
   - gender
   - dealing with feelings
   - confrontation/conflict
   - breaking bad news
   - euthanasia, death and dying
   - risk/benefits communication
   - malpractice
   - animal vector human diseases
3. **Communication with self**
   - clinical reasoning and problem solving
   - attitudes (awareness, expression of)
   - feelings (awareness, use/expression of)
   - reflection and self-evaluation skills
   - capacities (flexibility, compassion, integrity, respect, mindfulness)
   - dealing with stress and tension
   - handling mistakes
   - handling failures
   - dealing with biases and assumptions
4. **Communicating with professionals, teams (relational competence, coordination of care)**
   - veterinary colleagues
   - team members (formal and informal teams – allied professionals, technicians, assistants, etc.)
   - leadership communication
   - administrators
   - written communication (letters, medical records)
   - researchers (directly and through literature)
   - oral presentations, lectures, discussion facilitation
5. **Communicating at a distance**
   - telephone
   - telemedicine
   - computer-assisted consults
   - internet networks, databases, websites
6. **Prevention and health promotion (communicating with the public)**
   - internet, pamphlets, posters
   - radio, TV, newspaper campaigns
   - advertising
   - public speaking, discussion leadership
   - talking to the press
7. **Communicating with 'the system' (government, community, hospital, etc.)**
   - influencing health policy
   - talking with government, hospital, community and agency representatives
   - influencing and coping with change
8. **Veterinary–animal communication**
   - the human–animal bond
   - influences on human and animal health
   - interacting with patients – cross-species communication

C-C Guides: Calgary-Cambridge Guides

Adapted from: Kurtz S.M. *et al.* (15)

World Organisation for Animal Health (OIE) has promoted One Health as a framework for integrating multiple disciplines to improve health outcomes throughout the world, using collaborative efforts of interdisciplinary teams, working locally, nationally, and globally to attain optimal health for people, animals and the environment (22). Key words in these publications such as 'team', 'collaborative' and 'cooperative', suggest that we are not just talking about communication and cultural skills for veterinary education; we are talking about communication and cultural competencies that are necessary for interdisciplinary and international collaboration across all sorts of professional, cultural and geographical boundaries. Communication is one connecting force that we can use to move across the barriers that have existed between animal and human public health. We are not suggesting that an entirely new set of communication skills is required or reserved, for that matter, for the veterinary profession's work in global health. Instead what practice and education in veterinary and human medicine need are evidence-based programmes that teach and assess foundational communication skills and place greater emphasis on applying knowledge, capacities and specific communication skills to tackle the problems and issues of global public health in an evolving world.

If veterinarians are to work effectively in interdisciplinary and international arenas, cultural sensitivity is especially necessary. Most of us develop our cultural sensitivity and the communication skills needed to demonstrate that sensitivity over a very long time through the learning of other languages and considerable immersion in, or at least inquiry into, other cultures. The requisite sensitivity and skills are developed through relationships and conversations with clients or colleagues or government personnel, each of whom represent their own personal adaptations of their cultural groups. This long-term endeavour rightly begins by laying down strong foundations during veterinary medical training that we then build on as we extend the communication and cultural curriculum into residency and continuing veterinary medical education.

# Types of communication skills

Regardless of the domain, communication always involves three overlapping and interdependent types of skills (19) that communication training needs to consider.

## Content skills: what health professionals communicate

Content skills relate to the substance of what health professionals ask and talk about, the words they use to reveal their thinking and their medical-technical knowledge base.

## Process skills: how they communicate

Process skills relate to the way in which health professionals communicate, including how they:
– structure and organise what they say
– orient others to hear their messages
– ask questions (open-ended, closed, Socratic)
– develop and sustain relationships
– listen, engage and acknowledge others, and make space for them to speak
– use non-verbal skills
– explain or plan or set up shared decision-making
– express or demonstrate compassion, caring or understanding.

## Perceptual skills: what they are thinking and feeling

Perceptual skills refer to the thoughts, feelings, and capacities that lie behind what and how health professionals are communicating, including their:
– clinical reasoning skills
– medical problem-solving skills
– internal decision-making skills
– assumptions, biases and prejudices
– attitudes, values, intentions, and beliefs
– emotional intelligence, feelings about the others or the topics at hand, and other emotions that enhance or disable their communication
– capacities such as cultural sensitivity, flexibility, compassion, and others named in Box 2.

**Box 2**
**Capacities and other perceptual skills to emphasise in cross-cultural communication**
– Humility
– Flexibility
– Openness
– Integrity
– Adaptability
– Curiosity
– Intelligence
– Self-awareness
– Maturity
– Ability to be non-judgemental
– Recognition that values differ between cultures
– Recognition that accepted ways of using and interpreting non-verbal behaviour and understanding the meaning of specific words or phrases differ between cultures
– Recognition that veterinary education and the way in which it is practised differ from culture to culture

Defined this way, as a three-part set of interlinking skills, communication in veterinary and human medicine is a central clinical/professional skill, because it provides the conduit through which we actually accomplish the work of health care. Content skills are a focus of teaching throughout the veterinary medical curriculum. Communication programmes work at developing communication skills and capacities necessary for applying that knowledge base or content in the context of interactions with others, be they clients in clinical settings or government policy-makers or international colleagues with whom we are attempting to solve global health problems. The interdisciplinary, cross-cultural nature of global public health places particular emphasis on the development of perceptual skills related to assumptions and biases, flexibility and respect, and attitudes and beliefs. Equally important are the process skills required for developing and sustaining relationships and for achieving the mutually understood common ground that is at the foundation of trust and relationship.

## Relationship-centred care: an emerging paradigm

Relationships matter. They make a crucial difference to communication in both human and veterinary medicine, to the people and animals that are involved, and to the outcomes we achieve in both individual practices and global health contexts. Our ability to develop, deepen, and maintain relationships is a critical factor in how we practice medicine and also in how we conduct ourselves as teachers, policy-makers, administrators and students. With respect to global public health, relationships – and the trust on which they are grounded – are the bedrock of successful interdisciplinary and cross-cultural work. First introduced in 1994 in human medicine (21), Relationship-Centred Care (RCC) is a new paradigm for conceptualising veterinary service. It recognises that four sets of relationships are vital to veterinary medicine (4):

– veterinarian with patient, client and their significant others

– veterinarian with other care givers (colleagues, team members)

– veterinarian with community (practice, hospital, town)

– veterinarian with self (thought processes; emotional capacity; intentions, biases, beliefs, and values; attitudes; self-concept).

In all these contexts, relationship means reciprocal influence, that is, partnership. The underlying principles of RCC have been adapted to apply to any relationship-centred process (20). These adapted principles include:

– being personally present and inviting others to do likewise

– speaking the truth and listening to understand

– valuing difference and diversity as a resource

– letting go of control through attention to, and trust in, the process of interaction with the other individuals who are involved.

Relationship-centred process can apply to our daily personal and professional conversations, how we organise meetings, what we model and what we teach. What, if anything, about RCC does not apply to veterinary medicine and what do we need in order to prepare and activate our students to work globally? We propose that RCC, with its emphasis on the formation, maintenance and ongoing development of relationships, is a highly appropriate paradigm for veterinary medicine, whether we are developing communication curricula, delivering veterinary care or working in global public health. The communication skills and capacities inherent to the relationship-centred process must be part of what we teach our students.

## 'First principles' of effective communication

As is the case with other areas of clinical practice, when we do not know what to do, we go back to first principles. The first principles of effective communication (15) pertain to any communication situation and provide a useful shorthand for conceptualising how to communicate effectively. They provide guidance for our actions in the field and when making decisions regarding our teaching and assessment. Effective communication is communication that:

*a*) ensures interaction not just transmission of a message. Communication is more than the well-conceived, well-delivered message; it requires interaction, feedback – in a word, relationship;

*b*) reduces unnecessary uncertainty, for example, about roles and responsibilities, intentions, expectations, perceptions, etc.;

*c*) requires planning and thinking in terms of outcomes. You can only determine effectiveness in the context of the outcomes you and the other(s) are working toward;

*d*) demonstrates dynamism by engaging authentically with the other and also remaining flexible, developing a deep enough repertoire of skills to allow the use of different approaches with different people or contexts;

*e*) follows a helical rather than a linear model. Once is never enough. Effective communication, like effective teaching and learning, requires reiteration and repetition, taking feedback into account, coming back around the helix at a slightly higher level at each turn. The helix also serves as an excellent model for teaching and curriculum development (8).

The added complexity of cross-cultural communication requires us to raise the intensity with which we apply these principles.

## Evidence-based strategies and approaches for enhancing communication competence in global public health

The conceptual framework presented above defines the role of communication skills and cultural sensitivities in global public health and guides our thinking about what we need to teach regarding these important areas. Next, we turn to how to do that teaching.

Comprehensive literature reviews regarding communication training (2, 10, 15) identify experiential, learner-centred education as a best-practice approach to teaching and learning communication in health care. It is the most efficacious way to teach communication if what you are looking for is engaged learners who effectively enhance or change their behaviour, deepen their understanding, are able to apply both skills and understandings in real interactions with clients or others, and sustain their learning over time (15, especially pages 63 to 72).

Learners are 'active and interactive' participants in their own learning process and in that of their peers. Couple this with problem or inquiry-based learning in which learners have the opportunity to apply theoretical understanding to real-life situations and problems and you have participatory, learner-centred, experiential education.

Clearly, you cannot teach communication skills effectively by lecturing any more than you can teach someone to play tennis well by having them sit in front of you listening or discussing questions. So, what does it take to teach and learn communication skills in veterinary medicine? Research indicates that knowledge about communication skills and capacities and about their relative importance is useful, but not sufficient to change behaviour effectively. Several other elements emerge from the research that are essential if we want to enhance communication skills, change behaviour in practice, and sustain that learning over time (15):

– systematic delineation and definition of skills

– observation of learners communicating with clients, community members, colleagues or others (simulated and actual)

– video (or audio) recording of the interaction for later review

– well-intentioned and detailed descriptive feedback

– repeated practice and rehearsal of skills in a safe setting

– small group or one-to-one teaching format.

Two companion books (15, 19) offer a full description of these elements and how they combine to form coherent, rigorous communication curricula. This article focuses on delineating the skills and observing learners, touching lightly on the other elements.

The initial step in this list of essential elements is to delineate and define the skills – everything else depends on this first step. Numerous models have been developed in human medicine to delineate and define communication skills. For example, the Maas-Global model, the Segue Model, the Patient-Centred Care model, the Model of the Macy Initiative in Health Communication, and the Calgary-Cambridge Guides (C-C Guides). Most effective communication programmes are based upon models such as these.

Skills models and the feedback instruments through which they are presented constitute a particularly important part of the strategy for teaching communication. They summarise the communication skills curriculum and demystify communication. Used as guides to structure observation and feedback, the instruments help us identify individual learner's specific strengths and weaknesses and enable more systematic, concrete learning.

So, what specific communication skills are worth teaching? As an example, we will examine more closely the highly evidence-based and versatile C-C Guides (14, 15, 19). As is true of most instruments, the C-C Guides have gone through numerous iterations (in this case over the last 30 years) that drew on the work of medical colleagues in Australia, Canada, the United Kingdom (UK), the Netherlands, the USA, and elsewhere. Many medical students, faculty, and patients have added their feedback and suggestions. Over the last 10 years, veterinarians in Australia, the UK, and North America have begun to use the guides and added in their feedback and ideas.

The cross-cultural relevance of the C-C Guides is surprising. Used for communication training in countries on five continents, they enjoy widespread international recognition and have been translated into languages as

diverse as Arabic and Mandarin. The guides apply equally well to a variety of disciplines. Communication programmes in nursing and allied health professions, teacher education, and now veterinary medicine, are employing the guides with minor modification. Moreover, the exact same guides are being used with learners at every level of medical and veterinary education because there are no 'basic' or 'advanced' communication skills. There are only varying degrees of mastery and sophistication in applying the skills, and varying expectations for how far learners at different levels will take them. We are, of course, not suggesting that there are no communication differences across cultures. Undoubtedly it is important to learn the nuances of how to express respect in each culture, how best to greet others, how to use or interpret eye contact and other non-verbal skills appropriately, etc. However, the same communication process skills are important for effective communication regardless of the culture. That is why, rightly used, it is possible to use the C-C Guides across so many languages and cultures.

The C-C Guides form the backbone of the communication curriculum, regardless of whether we are teaching veterinary–client communication in the clinic or veterinary–colleague communication in global public health. The 71 items on the process guides provide a useable summary of the research literature on what makes a difference regarding communication in veterinary and human medicine. To make this comprehensive list more manageable and memorable, the skills are organised around the framework in Box 3. This framework corresponds directly to the tasks that are undertaken in any veterinarian–client interaction: initiating the session, gathering information (including communication skills associated with physical examination), providing structure, building relationship, explanation and planning, and closing the session. Building relationship and providing structure occur throughout the consultation, while all the other tasks occur more or less sequentially in any given interaction. Subheadings represent the aims clinicians need to accomplish within each task.

The guides comprise a four-page summary of the literature and of the communication programme. Offering evidence-based guidance with considerable flexibility for personal style, they provide a common vocabulary for referring to specific behaviours and form a common foundation for developing communication curricula from undergraduate through continuing veterinary medical education.

It is noteworthy that there is no communication domain in Box 1, or skill set on the C-C Guides in Box 3, labelled 'cross-cultural communication'. This is not as surprising as it may seem. Take another look at the objectives and outcomes we are trying to accomplish through communication in veterinary settings. These same objectives and outcomes pertain to veterinary service in global public health. The specific communication skills we need in order to accomplish these ends in cross-cultural settings are in fact the skills that appear on the C-C Guides. It is not the skills that vary, but the way we use them. When developing curriculum for communication in global public health, it is therefore useful to look first to see whether the skills that are important to cross-cultural communication are already being taught to an adequate level of competence in other contexts, such as the veterinary–client interview.

That said, cross-cultural sensitivity – or just plain ordinary sensitivity to anyone with views different from our own – does require that we use some communication skills with greater intensity or greater intentionality than would normally be the case. Box 4 offers a partial list of such skills. The sensitivity required to apply these skills flexibly to fit the particular needs of a given interaction is learned behaviour. If learners are to deepen their cultural sensitivity and enhance the communication skills that allow them to demonstrate that sensitivity, they must have opportunities to practise those skills in the context of

**Box 3**
**Expanded framework for the Calgary-Cambridge Guides: communication process Skills**

**Initiating the session**
- Establishing initial rapport
- Identifying the reason(s) for the patient's attendance

**Gathering information**
- Exploration of patient's problems
- Additional skills for understanding the patient's perspective

**Providing structure to the consultation**
- Making organisation overt
- Attending to flow

**Building the relationship**
- Using appropriate non-verbal behaviour
- Developing rapport
- Involving the patient

**Explanation and planning**
- Providing the correct amount and type of information
- Aiding accurate recall and understanding
- Achieving a shared understanding: incorporating the patient's perspective
- Planning: shared decision-making
- Options in explanation and planning:
  - if discussing opinion and significance of problems
  - if negotiating mutual plan of action
  - if discussing investigations and procedures

**Closing the session**
- Forward planning
- Ensuring appropriate point of closure

cross-cultural or interdisciplinary cases in which the client or colleague holds beliefs or values that differ from those of the learner.

Language itself causes problems of interpretation and understanding. This is true even when both speakers are fluent in the language they are speaking, for example, when they are familiar with different vocabularies or when they come from different cultural bases or different disciplines. Language issues can become even more problematic when one or more of the people involved in an interaction are speaking a language other than their mother tongue.

Well-trained interpreters can be very helpful in the latter situation. However, translating is rarely a straightforward process. Interpreters can actually expand problems of understanding, for example, if they are themselves from a different culture and have not developed cultural as well as linguistic competence regarding a given speaker's particular cultural and linguistic context or if they choose to summarise blocks of conversation rather than translating everything that a speaker has said.

Another resource for learning cultural sensitivity in a particular context is a trusted confederate, that is, someone who is a member of a given cultural group and a native speaker of the language in question. Cross-cultural communication difficulties can be greatly reduced by developing a relationship with such a person whom you can ask directly as needed about nuances of meaning, puzzling situations or appropriate non-verbal and verbal behaviour.

To resolve or at least ameliorate potential problems of interpretation and understanding – even if you are working with an interpreter or a confederate – some communication skills are particularly important:

– listening and observing carefully/mindfully when conversing with someone who comes from a cultural context different from your own, so that you (learn to) recognise when you may be misinterpreting what they are saying or doing and/or when they may be misinterpreting you;

– asking questions or paraphrasing frequently to confirm your interpretations and, as soon as you sense that you (or they) may not be interpreting or understanding something correctly, learning to express requests for clarification succinctly and sensitively, e.g. 'I'm not sure I'm understanding you correctly; can you help me out – do you mean _____?' 'Is it appropriate in your culture for us to shake hands or is there another form of greeting that you would prefer?'

– returning to careful/mindful listening and observing as the other person responds to your questions and other requests for clarification.

Students have to learn how to apply relevant communication skills and capacities appropriately in cross-cultural settings and public health contexts. To give them this opportunity we need to work with existing communication courses to encourage the inclusion of case material that involves, for example, colleague-to-colleague communication or veterinarian-to-policymaker interactions in addition to veterinary–client communication. Some of the case material might also shift from local to international settings or from veterinary colleague to colleagues in another discipline related to global public health, such as human medicine or anthropology.

One way to set up case material is through simulation. Why would we use this method to teach communication skills and cultural sensitivities? Simulated clients (SCs) are trained individuals who accurately and consistently present a particular case to medical or veterinary professionals or students. Ideally, simulations are always based on real cases, including the animal's circumstances and the personalities, perspectives, and responses of the real people who were involved. Simulated patients have been used in medical teaching since the 1960s and are used extensively to teach medical students communication skills as well as biomedical and clinical examination skills (3). The use of SCs in veterinary medicine is relatively new (1) and several schools in North America, the UK, Ireland and Australia have started to use SCs in communication

**Box 4**
**Process skill-sets to emphasise in cross-cultural communication**

Relationship building (skills for developing and maintaining relationship)
Establishing mutually understood common ground (the basis for trust)
Developing and sustaining mutual trust
Accurate information exchange – checking for understanding
Eliciting and acknowledging the other person's perspectives, especially when they differ from our own
Demonstrating empathy
Attentive listening (deep listening)
Engaging in shared decision-making
Identifying our own intentions and assumptions
Non-verbal communication (appropriate for the culture)
Relational coordination (skills for coordinating efforts with others)
Dealing with conflict and defensiveness
Responding to mistakes, admitting our own errors
Putting together well-conceived, concise messages and delivering them in a culturally sensitive manner
Demonstrating each of the capacities and perceptual skills listed in Box 3

skills training (11, 16). Some programmes use simulated-client scenarios to emphasise difficulties of communication between cultures. Examples of these scenarios include cases in which language is a barrier, or the client and his cultural group view a pet's obesity as a sign of prosperity, or religious beliefs lead the client to decline transfusion as a treatment option for their animal.

Simulation does not take the place of supervised practice in real-life settings. Rather, simulation offers a completely safe environment in which experimentation is encouraged and mistakes and failures do not result in harm. Moreover, learners can 'rewind' parts of the interview to give the original interviewer a chance to try an alternative communication approach or to see how a colleague would handle the situation. Video-taping of either simulated or 'real' interactions, with informed consent of all involved is an invaluable addition that offers learners a check and balance for their own perception and self-assessment, a feedback and teaching tool for the group, and a way to focus on specific points of strength or weakness. During video review, the facilitator or a fellow learner takes on the role of the client or colleague rather than a simulator. To our knowledge only a few schools are using simulation, video and in-depth feedback as a means for individuals to develop the communication skills needed to respond to the complex issues emerging in global public health.

Given the limited time we have for communication overall in veterinary medical curricula and for teaching global animal and public health in particular, it is unlikely that we can achieve the goal of well-developed cultural sensitivity for all students. It requires more than a couple of lectures or a workshop. However, we can open this discussion, and we can raise awareness.

Teaching the particular nuances required in various cultures is not a simple task. Training that takes cultural differences into account can inadvertently and all too easily become an exercise that instead reinforces stereotypes. Cultural groups are rarely homogeneous anymore. In fact, a study comparing health beliefs and access to care of over 20 different cultural/ethnic groups, found greater differences within cultural groups than between them (5). A high degree of thought and attention must be paid to ensure that those teaching communication and cultural skills and their learners address this potential to stereotype. As we mentioned earlier, international colleagues and collaborators are essential to the design, development and delivery of the communication curriculum. Simulated cases, for example, cannot be made up. Simulation, feedback sessions, and other teaching must be informed by consultation with key cultural informants. The same is true when we are developing case scenarios about, for example, a North American swine producer. So again, the educational principles that we have been talking about for a global health curriculum are not unique to cross-cultural communication.

## Preconditions necessary to initiate and sustain a communication curriculum relevant to cultural diversity and global animal health

In addition to identifying contents and methods for the communication and cultural skills curriculum, a number of preconditions must be considered for this type of curriculum to be successful. There are two places to teach communication skills and cultural sensitivities: in the dedicated communication course and in other parts of the veterinary curriculum where global animal health is taught. Success begins with administrative support, including leadership that ensures creation of sufficient space in the curriculum. Without dedicated time to teach communication, faculty will be left to scramble to add communication training piecemeal or not at all to existing courses. The fact that most faculty did not get communication training in their own education makes this all the more difficult. On the other hand, designing parts of the communication curriculum to be integrated with the rest of the curriculum is also important. Such integration might impact student and faculty perception about the importance of this aspect of the programme, not to mention the impact on student's ability to work toward mastering skills necessary for working in local as well as global contexts.

Solid communication curricula are, of course, not yet widespread in veterinary training. So perhaps the most important precondition is to develop and implement evidence-based communication curricula on which to build better training in cross-cultural sensitivity. It will require commitment and hard work to expand the communication curriculum and take on cross-cultural educational challenges that will prepare students to work globally or inter-culturally.

Another considerable contributor to the success of a communication and cultural skills curriculum is support for ongoing faculty development to enhance ability to teach and model communication effectively so as to serve the global public health agenda. Faculty must know both what to teach and how to teach it. International fieldwork experience is worth considering as we make decisions about new faculty recruitment. Encouragement and

support for veterinary faculty and students to engage in international fieldwork experiences or related research projects is also needed if schools of veterinary medicine are to be effective in meeting their responsibilities regarding global health. A related consideration is partnership with and/or hiring of interdisciplinary teachers, including anthropologists, economists and so forth to work directly with veterinary faculty and students. We need to ensure that we have coordination of effort in our own schools. Training and recruiting faculty who can model the skills that are vital for cross-cultural work, providing time in the curriculum to employ the educational models discussed above, and formally integrating communication and cultural skills into clinical and other discipline courses are essential. An interdisciplinary team of teachers including representation of those from the international landscape is also important.

Additional requirements include physical space for communication teaching and people to assist with and coordinate implementation of the curriculum. As we outlined earlier, the educational models for skills-based teaching require small-group teaching space and audiovisual equipment. While several schools have or are constructing appropriate facilities to teach small groups, many others are trying to do the work using inadequate space allocations.

Other preconditions require us to visit some deeply held beliefs about the prerequisite courses that are thought necessary for students entering veterinary school. Although not traditionally required, pre-entry training might usefully include courses such as anthropology, sociology, political science, religious studies, social work, and qualitative research methods. We should also consider the non-cognitive attributes that our students need coming into our programmes; such attributes will help set students up for success with the type of skills-based and capacity-oriented curriculum outlined in this paper. The University of Calgary Faculty of Veterinary Medicine (UCVM) experimented with one approach for doing this in their admissions interviews for the inaugural class (2008) of veterinary medicine applicants (12). Called the Multi-Mini Interview (9) the process assessed whether or not the applicant had the non-cognitive attributes that were deemed essential for the curriculum at Calgary. The interview focused on features such as knowledge of veterinary medicine, moral and ethical reasoning, teamwork and interpersonal skills, empathy, career adaptability, procedural skills, and the value potential students placed on animal and human life. We might also need to address the homogenous nature of our student bodies and think more critically about the role and importance of 'selecting students' from a variety of cultural and ethnic backgrounds or with broad cross-cultural experience and interest in global public health.

Our graduates' preparedness to work within a global environment requires more than impromptu visits to other countries on the part of both students and faculty. Success is dependent on clear differentiation between 'travelling' more or less as an adventure tourist and interacting as a partner to achieve mutually defined and agreed upon goals. Success depends on a conceptual educational framework and a curriculum that sustain experiential learning of communication and cultural skills for a vast array of interactions around the world. To facilitate the cultural aspect of this educational paradigm we require international partners and affiliations. This will include visiting teachers and guests who can assist us with preparing our students for the cultures in which they will be collaborating. Encouraging student and faculty participation in international work raises the issue of the funding that may be necessary in order to offer the type of programme suggested here. While there are a number of experiences that we can expose our students to within the veterinary school we must also consider international and interdisciplinary opportunities for them, as part of their undergraduate and, more likely, graduate training. To do this we need to generate funds to allow faculty and student exchanges that bring representatives from diverse cultures onto each other's campuses.

For our communication skills and cultural sensitivity curricula to retain credibility and accountability, our faculty and students should be supported to engage in research that looks at global public health outcomes as well as questions related to veterinary medical education. Outcome-based curricula, aimed at mastery learning will put pressure on us to review and possibly revise the educational models and methods that dominate veterinary curricula and our student evaluation. It is important to plan and coordinate a well thought out assessment strategy that is heavily based on formative assessment as a mechanism for providing concrete, detailed feedback rather than relying on assessments that are simply an exercise in psychometrics. Due consideration of these non-traditional models will also require that we carefully examine the preconditions named here and look for others not mentioned, so as to ensure that we have the resources to design, deliver and sustain this type of curriculum.

# Conclusion

Communication skills and capacities necessary for effective cross-cultural communication are in essence the same as communication skills in action anywhere else in veterinary service. What are needed are communication curricula to assist students in learning to apply those skills and capacities specifically in global health settings. We stand by the underlying premise that no matter what area of veterinary service our students participate in they should

leave school with a baseline of communication competence and then continue to develop it, throughout their career, to a professional level of competence. The research in support of the relationship between communication and important outcomes is too compelling to refute.

■

# Les compétences fondamentales en communication et la sensibilisation à la diversité culturelle dans le domaine de la santé publique vétérinaire mondiale

S.M. Kurtz & C.L. Adams

**Résumé**

L'exercice de la médecine vétérinaire et de la santé publique mondiale requiert des compétences en communication qui s'avèrent aussi importantes que les aptitudes cliniques et la possession d'un bon bagage de connaissances. La communication et la prise en compte de la diversité culturelle sont des compétences absolument essentielles pour exercer la médecine vétérinaire dans une perspective aussi bien pluridisciplinaire qu'internationale et locale. Cet article propose un cadre documenté et structuré en trois parties, permettant d'élaborer et de faire évoluer des programmes de formation destinés à renforcer les compétences en communication et à sensibiliser à la diversité culturelle, afin de préparer les étudiants à exercer la médecine vétérinaire dans un monde en pleine mutation. Ces programmes peuvent également inciter un plus grand nombre de vétérinaires diplômés à s'orienter vers la santé publique mondiale.

**Mots-clés**

Communication – Contenu de l'enseignement – Culture – Enseignement de la médicine vétérinaire – Santé animale mondiale – Soins centrés sur le relationnel – Une seule santé.

■

# Enseñanza básica en materia de comunicación y aspectos culturalmente delicados con vistas a una salud pública veterinaria de ámbito mundial

S.M. Kurtz & C.L. Adams

**Resumen**

En la praxis de la medicina veterinaria y la salud pública mundial, la capacidad de comunicación es tan importante como la aptitud para el análisis clínico o la posesión de un extenso acervo de conocimientos. El hecho de saber comunicar con eficacia y de ser sensible a las diferencias entre culturas es también indispensable para el ejercicio interdisciplinar de la medicina veterinaria en toda circunstancia y en los planos tanto internacional como local. Los autores ofrecen un sistema de referencia en tripartito para elaborar y perpetuar planes de estudios que mejoren la capacidad de comunicación y la sensibilidad

transcultural de los estudiantes, que así estarán más preparados para ejercer la veterinaria en un mundo sujeto a cambios constantes. Esos planes de estudios también pueden servir para alentar a un mayor número de titulados en veterinaria a adentrarse profesionalmente en el terreno de la salud pública mundial.

**Palabras clave**
Comunicación – Cuidados centrados en las relaciones personales – Cultura – Enseñanza de la medicina veterinaria – Plan de estudios – Sanidad animal mundial – Una salud.

# References

1. Adams C.L. & Ladner L.D. (2004). – Implementing a simulated client programme: bridging the gap between theory and practice. *J. vet. med. Educ.*, **31** (2), 138-145.

2. Aspergren K. (1999). – Teaching and learning communication skills in medicine: a review with quality grading of articles. *Med. Teacher*, **21** (6), 563-670.

3. Barrows H.S. (1993). – An overview of the use of standardized patients for teaching and evaluating clinical skills. *Acad. Med.*, **68** (6), 443-451.

4. Beach M.C., Inui T. & the Relationship-Centered Care Research Network (2006). – Relationship-centered care: a constructive reframing. *J. gen. internal Med.*, **21**, S3-S8.

5. Chugh U., Dillman E., Kurtz S.M., Lockyer J. & Parboosingh J. (1993). – Multicultural issues in medical curriculum: implications for Canadian physicians. *Med. Teacher*, **15** (1), 83-91.

6. Coe J.B., Adams C.L. & Bonnett B.N. (2007). – A focus group study of veterinarians' and pet owners' perceptions of the monetary aspects of veterinary care. *J. Am. vet. med. Assoc.*, **231** (10), 1510-1518.

7. Coe J.B., Adams C.L. & Bonnett B.N. (2008). – A focus group study of veterinarians' and pet owners' perceptions of veterinarian client communication in companion animal practice. *J. Am. vet. med. Assoc.*, **233** (7), 1072-1080.

8. Dance F.E.X. (1967). – Toward a theory of human communication. *In* Human communication theory: original essays (Dance F.E.X, ed.). Holt, Rinehart and Winston, New York.

9. Eva K.W., Rosenfeld J., Reiter H.I. & Norman G.R. (2004). – An admissions OSCE: the multiple mini-interview. *Med. Educ.*, **38** (3), 314-326.

10. Fallowfield L. & Jenkins V. (2006). – Current concepts of communication skills training in oncology. *Recent Results Cancer Res.*, **168**, 105-112.

11. Gray C., Blaxter A.C., Johnston P.A., Latham C.E., May S., Phillips C.A., Turnbull N. & Yamagishi B. (2006). – Communication education in veterinary medicine in the United Kingdom and Ireland: the NUVACS project coupled to progressive individual school endeavours. *J. vet. med. Educ.*, **33**, 85-92.

12. Hecker K., Donnon T., Fuenteabla C., Hall D., Illanes O., Morck D. & Muelling C. (2009). – Assessment of applicants to the veterinary curriculum using a multiple mini-interview method. *J. vet. med. Educ.*, **36** (2), 166-173.

13. Institute of Medicine (1997). – America's vital interest in global health: protecting our people, enhancing our economy, and advancing our international interests. National Academies Press, Washington, DC.

14. Kurtz S., Silverman J., Benson J. & Draper J. (2003). – Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. *Acad. Med.*, **78** (8), 802-809.

15. Kurtz S., Silverman J. & Draper J. (2005). – Teaching and learning communication skills in medicine, 2nd Ed. Radcliffe Publishing, Oxford.

16. Radford A.D., Stockley P., Taylor I.R. *et al.* (2003). – Use of simulated clients in training veterinary undergraduates in communication skills. *Vet. Rec.*, **152**, 422-427.

17. Shaw J.R., Adams C.L., Bonnett B.N. *et al.* (2008). – Veterinarian-client-patient communication during wellness appointments versus appointments related to a health problem in companion animal practice. *J. Am. vet. med. Assoc.*, **233** (10), 1576-1586.

18. Shaw J.R., Bonnett B.N., Adams C.L. *et al.* (2006). – Veterinarian-client-patient communication patterns used during clinical appointments in companion animal practice. *J. Am. vet. med. Assoc.*, **228**, 714-721.

19. Silverman J., Kurtz S. & Draper J. (2005). – Skills for communicating with patients, 2nd Ed. Radcliffe Publishing, Oxford.

20. Suchman T. (2008). – Four principles of relationship-centered process. Workshop presentation, adapted from Brown J. (2007), A leader's guide to reflective practice. Trafford Publishing, Victoria, British Columbia.

21. Tresolini C.P. & the Pew-Fetzer Task Force (1994). – Health professions education and relationship-centred care. The Pew-Fetzer Task Force on Advancing Psychosocial Health Education, Pew Health Professions Commission and the Fetzer Institute, San Francisco.

22. World Organisation for Animal Health (OIE) (2008). – The new tool for the evaluation of performance of Veterinary Services (PVS Tool) using OIE international standards of quality and evaluation. Available at: www.oie.int/eng/oie/organisation/en_vet_eval_tool.htm?eld2 (accessed in November 2008).