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BEING ON GUARD VS *BEING IN BLINKERS:* PERSPECTIVES ON THE INTERCULTURAL COMPETENCE WITH FOREIGN MEDICAL STUDENTS IN ROMANIA. ASPECTS OF EVALUATION

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ABSTRACT. ***Being on guard vs being in blinkers: perspectives on the intercultural competence with foreign medical students in Romania. Aspects of evaluation.*** The development of intercultural competence (IC) in the 21st century is a clear necessity, and not a socio-political trend. If in the United States circumstances have imposed for decades the establishment of a new discipline, Europe sees itself now confronted with the emergency of establishing intercultural teaching principles, in the face of massive immigration and an explosion in educational and occupational mobility. If we relate to the second category, foreign medical students in Romania respond to a double wager of understanding Romanians: the street and the hospital medium. From a pedagogical perspective, the work group is homogeneous, so that teaching transcultural knowledge, attitudes and abilities does not raise major problems. However, evaluation represents a challenge: it is not a question of knowledge, where there already are multiple instruments that have been verified, but about attitudes and abilities, which are monitored in time and in specific contexts, and the RFL teacher rarely benefits from such circumstances. In the present study, „ *Being on Guard* Vs *Being in Blinkers:* Perspectives on the Intercultural Competence with Foreign Medical Students in Romania. Aspects Of Evaluation", we try to build some evaluation activities and exercises that are specific for each component of the intercultural competence, and which are adapted to the students' curriculum and schedule.

Keywords: *intercultural competence, evaluation, attitudes, abilities, integrated activities.*

REZUMAT. ***Cu ochii în patru vs. cu ochelari de cal: perspective asupra competenței interculturale la studenții medicinişti străini din România. Aspecte ale evaluării.*** Dezvoltarea competenței interculturale în secolul XXI este o

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necesitate clară, nu un trend sociopolitic. Dacă în Statele Unite circumstanţele au impus de câteva decenii deja constituirea noii discipline, Europa se vede acum confruntată cu urgenţa constituirii principiilor didactice interculturale, în faţa imigraţiei masive şi a exploziei mobilităţilor educaţionale. Dacă ne raportăm la a doua categorie, studenţii străini medicinişti din România răspund unui dublu pariu al înţelegerii românilor: strada şi mediul spitalicesc. Din perspectivă pedagogică, grupul de lucru e omogen, deci predarea cunoştinţelor, atitudinilor şi abilităţilor transculturale nu ridică probleme majore. Însă evaluarea e o provocare: nu e vorba de cunoştinţe, unde deja există intrumente multiple şi verificate, ci de atitudini şi abilităţi, care se monitorizează în timp şi în contexte specifice, iar profesorul de RLS dispune rareori de asemenea circumstanţe. În studiul de faţă încercăm să construim câteva activităţi şi exerciţii de evaluare specifice pentru fiecare componentă a competenţei interculturale, adaptate la curriculumul şi orarul studenţilor noştri.

Cuvinte cheie: *competenţă interculturală, metode de evaluare, atitudini, abilităţi, activităţi integrate.*

1. Introduction

In the academic environment, the intercultural competence (IC) is generally associated with communication competences. European language policies have initially included it in the *Common European Framework for Languages*, and subsequently assigned it an individual space that is still directly associated with the levels and grids from the aforementioned document. In the past years, the stress has been less on the teaching methodology and more intensely on the ICC evaluation, both in the European space and in the American educational environment. The creation of evaluation grids that are specialised and adjusted in accordance with the present socio-historic needs determines a constant process of re-thinking the teaching and the types of activities that can be evaluated with the new instruments. We will review the stage of the results within the Western space: the directions outlined in Brussels, from their present early stage, and the American instruments of evaluation, with wider experience time-wise, which allowed them validation and diversification within specialized contexts. This diversification is especially useful for the present study, since we will follow the evaluation process of the IC in foreign students from medical schools in Romania.

What are the risks that the medical personnel exposes itself to if it neglects or ignores the intercultural competence? Firstly, to the same risks as in other fields and contexts: deformed or blocked communication,

stereotyping, generalization, racism. Furthermore, in the clinical environment what can arise are inequalities in treating patients and a discriminating treatment based on race, culture, language, religion, social status etc.

As a result, the usefulness of teaching and evaluating the IC of the over 10.000 foreign medical students in Romania[2] is beyond any doubt. We consider that, if there are no classes exclusively dedicated to the abilities in questions, although these would be equally useful for Romanian students, this competence could be included within the Romanian language course that future doctors take either during the Preparatory year or during the first two or three years of medical studies, in accordance with the academic curriculum. Our previous studies had as a central point the development of the curriculum for IC (Ursa & Mărcean, 2006/1, 2006/2), but the present article begins a new series of content analysis and development in the evaluation process, especially in the medical context.

2. Methods of evaluating the intercultural competence. A comparative presentation

As mentioned above, multicultural education, whether general or medical, has a longer experience in the United States, through the force of historic circumstances. In Europe, without it being something new, multiculturality has only recently begun to be built on a separate curriculum, with objectives that are evaluated quantitatively or qualitatively. In what follows, we will present and compare two monitoring models of the IC, one American and one European, which are probably the most popular in the literature. The models in questions are the DMIS and the INCA belonging to Bennett (1993) and Byram (1997), respectively, which have subsequently generated replicas, extensions, and sets of tests. Still in this section, we will discuss the evaluation instrument that is specific to interculturality within the clinical environment. The Association of American Medical Colleges created the TACCT, which is a set of items that help every institute of medical education in the United States to more easily integrate the ICC in their own academic programmes.

2.1. The DMIS (Developmental Model of Intercultural Sensitivity). Doctor Milton Bennett's model describes six stages of development which allow an objective observation of the evolution of a person from ethnocentrism (denial, defense, minimization) to ethnorelativism (acceptance,

[2] http://www.rfi.ro/social-85336-numarul-studentilor-straini-romania-s-dublat-zece-ani-interviu-audio; http://www.zf.ro/profesii/educatia-la-export-peste-20-000-de-studenti-straini-invata-in-facultatile-romanesti-14978309

adaptation, integration). One cannot speak of a grid, but rather of a scale, but it is a useful instrument in the evaluation of the sensitive reaction of a person in an encounter with another person or a group that is culturally different. We have summarised the details of the stages in an explanatory table, which allows for a rapid check.

Table 1. Bennett's Model (1993: 25)

ETHNORELATIVISM	6. Integration	One interprets the behaviour of the interlocutor from multiple cultural perspectives. One recognises that the perspective on the world is a collective construct.
	5. Adaptation	One uses the knowledge about one's own culture and about different cultures in order to make a rapid switch from one paradigm to another. One can empathise with values and behaviours that are different from one's own.
	4. Acceptance	One enjoys recognising and analysing cultural differences. One does not agree with all of them, but respectfully and curiously accepts them.
ETHNOCENTRISM	3. Minimization	One believes that one's reference points are universal. One has the tendency of vulgarizing and romanticising other cultures.
	2. Defense	One observes the differences between one's own culture and that of others, but attaches negative epithets to the latter. The tendency is of considering oneself as a cultural reference point, while '*the other*' is 'underdeveloped', 'inferior'.
	1. Denial	One considers that one's own culture is the only one that validates reality. One avoids observing and confronting oneself with different perspectives.

The biggest benefit of the proposed grid is announced by the author himself: by being very practical, it determines the accurate placing of individuals or groups in the adequate intercultural stage and allows the trainers to appropriately adapt the contents, namely the rhythm of the activities, so as to facilitate the students' crossing to the next stage (Bennett, 1993: 68). According to the theoretician, the students who take modules on interculturality can get from the first stage to the fifth stage within two years at the minimum.

2.2. The INCA (Intercultural Competence Assessment). The name of professor Michael Byram is associated with the construction of the educational scaffolding for the intercultural communication competence – the ICC, as he legitimizes it in the literature – within the European language policies from the past 20 years. In his 1997 study, he takes over interculturality from the CEFL, chapter 5, which is dedicated to general competences, and transforms it from a minor objective into a star of modern European education. That is when he also built the first specific grid, with content elements in the learning process of the ICC. Subsequently, he will also supply an attainment grid with six6 components (see Annexe), used by the evaluator, and an assessee grid with three sections: openness, knowledge and flexibility.

The ICC project followed the model of the European Language Portfolios (ELPs), with its three components – Passport, Biography and Dossier – which were adapted to intercultural learning are easy to download from their respective sections of the website of the European Council (https://ec.europa.eu/migrant-integration/librarydoc/the-inca-project-intercultural-competence-assessment).
First, there is a *Passport* that includes evaluation and self-evaluation grids. For that matter, the textbooks associated with it have developed differently, from the perspective of the evaluator and of the evaluated subject. Byram and his team's INCA project started in 2004 with the declared purpose of offering instruments that are easy to use in appreciating the intercultural competence of those who communicate in diverse contexts, while the main grip offers transparency, coherence and compatibility between the evaluated elements (see Annexe). Then, the *Biography* section records relevant personal intercultural experiences, self-reflection upon the encountered behaviours, journal entries about the encounters with individuals from different cultures. Finally, the *Dossier* encourages participation through personal accounts about the direct experience with the proposed evaluation grids, from the perspective of the teacher or of the student.

The grids evaluate attitudes, knowledge or skills on three levels of intercultural performance, *basic, intermediate* and *full* competence, reminiscent of Bennett's scale. One starts off from the idea that there is no zero level of ICC, and that by the nature of the present civilization, the home, educational and social environment has already modelled, whether programmed or not, the minimal level.

Tabel 2. Scala INCA simplificată (INCA 1: 7-8)

Basic competence	The individual is reasonably tolerant, with the intention of reacting well, but responds spontaneously, not planned.
Intermediate competence	The person offers a neutral response to difference, but there is the intention of preparing a reaction that is socially adequate for unfamiliar situations.
Full competence	The person is ready at any time to make use of a wide repertoire of strategies, knowledge and skills in order to efficiently manage the difference.

In the evaluation, one of the above levels is chosen for six constitutive elements of the ICC (tolerance of ambiguity, behavioural flexibility, communicative awareness, knowledge discovery, respect for otherness and empathy), which are combined in pairs to form three sections: openness / respect for others, knowledge / empathy and adaptability / flexibility.

Last but not least, it is important to know that the INCA has a standardised structure, comprised of 4 distinct parts. The first two have the role of collecting biographical data and of understanding the intercultural profile of the person who is evaluated. The third part proposes a *scenario*, for which items are constructed, in order to appreciate the student's reaction. The last exercise from this section is always a role-playing game, with the offering of indications. In the fourth part what appear are generally specific questions that are based on a text or on a video recording, plus a collective role-playing game, in which the student interacts with several colleagues while he/she is being observed and evaluated according to the attainment grid. For the first three sections the items constructed are of the T/F, multiple choice, open-ended questions type, in order to separately verify each of the six components of the ICC. For the fourth part, the performance of the person who is evaluated is each time measured in a table with the six components of the competence and according to the criteria from the grid. The combined efficiency of the type of test and the exhaustive grid determines us to personally opt for such a model within university practice. As a result, in the last section we will propose a concrete evaluation on an INCA model.

2.3. The TACCT (Tool for Assessing Cultural Competence). This grid is different from the previous ones, firstly because it is created for institutions and not for individuals. In the year 2000, the committee that dealt with the accreditation of the departments of medical education from the United States and Canada introduced new standards in the process of institutional evaluation, both referring to the doctor-patient communication, respectively to preconceptions and blockages generated by the low level in the competence in question. As a result, there is no scale, no grid for evaluating the individual competence, as in the previous models, but a series of closed items of the YES / NO type that refer to what was and was not covered in the first three years of medical studies, i.e. an evaluation of the institutional curriculum. However, for the undergraduate medical education, it is a valuable resource of educational objectives that ensure a correct and complete access to learning / evaluating the cultural competence. The authors (Lie et al., 2008) have prepared series of five domains for a pre-clinical year and a clinical year (clerkships):

Domain I: Cultural Competence Rationale, Context, and Definition
Domain II: Key Aspects of Cultural Competence
Domain III: Impact of Stereotyping on Medical Decision-Making
Domain IV: Health Disparities and Factors Influencing Health

Domain V: Cross-Cultural Clinical Skills

Each domain includes between 8 and 18 closed items. Below there is an illustrating example for domain V, in which the results that need to be reached by the students are preceded by the symbol letter for knowledge, skills and attitudes. Beyond indicating the ideal path, as the authors themselves state – we know little about implementing the evaluation and its objectivity.

K1. IdentifyK1. Identify community beliefs & health practices
K2. Describe cross-cultural communication models
K3. Understand physician-patient negotiation
K4. Describe the functions of an interpreter
K5. List effective ways of working with interpreter
K6. List ways to enhance patient adherence
S1. Elicit a culture, social, and medical history
S2. Use negotiating and problem-solving skills
S3. Identify need for & collaborate with interpreter
S4. Assess and enhance patient adherence
S5. Recognize and manage the impact of bias
A1. Respect patient's cultural beliefs
A2. Acknowledge the impact of physician biases

Before finalizing this section dedicated to presenting the evaluation grids, we need to underline certain shortcomings that we have observed in all of the mentioned models. Firstly, their validity is relative. Certainly, each of the three models have been implemented in varied contexts. However, we have not encountered, in the literature, any study that is relevant through the investigated sample, meaning through a large enough number of participants to allow an empirical re-evaluation of the criteria that were initially proposed. The second vulnerability, which for the moment cannot be prevented by IC tests, stems from the fact that the persons who are tested display a simulated behaviour when it comes to attitudes. There are individuals who, for a positive feedback and a high grade act *as if* they were curious, open and tolerant. Fortunately, there are two possible remedies that minimise the dishonest behaviour: either an attitude centred questionnaire at the end of the test or an optimist presupposition that the person who is being evaluated is capable to perfom, by simulating just as efficiently, in both real and spontaneous contexts (Lenz & Berthele, 2010: 29). We consider however that the greatest danger can come from the conviction of the individuals involved in teaching and evaluating the IC, trainers and trainees, that there is a supreme position of the sensitive tolerance towards others, a centre of the world, whether it is white, Western, heterosexual or of a certain religion etc. (Wear, 2003: 550). There one can in no way talk about interculturality, but about centre-culturality. The models of intercultural evaluation that have already been proposed or that are being created should reflect on the fine line between types of tolerance, and maybe even on the exclusion of the term itself.

We stop here with the presentation of the instruments for evaluating the ICC, although they are numerous and almost each of them brings, beside an increase in the objectivity and measurability within evaluation, ideas for a correct re-modelling of the taught contents as well. BASIC, ICSI, CCAI or IDI are just some of the models that bring us professional criteria. Paula Garret-Rucks offers a useful comparative analysis, without it being exhaustive (Garret-Rucks, 2012: 13-14). However, the mentioned models all follow the path of evaluating based on quantitative criteria. Or, for a soft competence, such as interculturality, we consider that the qualitative descriptors are more nuanced and apt to capture the differences in performance, especially in the case of attitudes and skills. As a result, in the last section of the paper we will return to the suggestions from the INCA grid, which we consider to be both the most complex and the most adapted to the evaluation of the targeted objectives, in order to identify efficient ways of constructing the items in evaluating the IC.

3. Constructing a test model in the process of evaluating the IC

3.1. Components, objectives, teaching activities and instruments of evaluation for IC

Since we have not yet found syllabi or teaching instructions for the intercultural competence in the curriculum associated with teaching foreign languages, especially with teaching Romanian as a foreign language (RFL) and Romanian for specific purposes (RSP), we propose below two simplified instruments that are useful in forming and evaluating the IC. If the first table is more general, with a more general addressability, the second one is conceived especially for medical students. Beside the sources discussed in the previous section, we have used recommendations and taxonomies from the specific bibliography (Betancourt & Cervantes, 2009: 472).

Table 3. Component elements and general techniques in IC

Attitudes	Knowledge	Skills
Modesty; Empathy; Curiosity; Respect; Sensitivity; Being aware of the interlocutor's cultural influences.	Knowledge about attitudes, values, beliefs and behaviours of cultural groups.	Skills to communicate with patients from different cultural groups.

Useful techniques for IC		
Self-reflection; Expressing an opinion about preconceptions, tendencies of stereotyping; Appreciation of personal values, of beliefs and of behaviours.	Models of avoiding lists of traits, thus of an over-simplification; Being aware of the cultural fluidity, of the traits that are changing for groups.	The capacity to manage the communicational situation after finding out the information; The capacity to solicit the explanatory model of the interlocutor / patient.

Table 4. Exercises and activities in teaching and evaluating IC

Exercises and activities for TEACHING-LEARNING IC for medical students		
Open conversations about the impact of racism, sexism and other types of discrimination in healthcare; A discourse about how they felt to be seen as 'different'; The determination of one's own reaction before picture with different races and ethnicities; Discussing the manner in which the members of one's own family interact with the healthcare system.	Receiving written or audio texts about the specificity of the community with which they will enter in contact; Ethnopharmacology exercises: the incidence and prevalence of diseases, the compliance with the treatment, specific practices of healing that can interfere with the recommended treatment, historic factors.	Exercises for identifying the explanatory model of the patient for his/her disease; Opinions about the patient's dependency on the family / doctor in taking decisions; Dialogues about the patient's perception of alternative medicine; Techniques of surpassing the problems of the patient's mistrust in the doctor / the healthcare system.
Exercising and activities for EVALUATING the IC for medical students		
Role-playing game (doctor-patient); Structured interview; Self-evaluation; Presentation of a clinical case; Video with a recorded consultation.	Pre-testing and post-testing; True / False, multiple choice; Presentation of a case study.	Recording of a consultation (video or audio); Role-playing game: offering indications; Presentation of clinical case.

3.2. The intercultural challenges of the foreign medical student in Romania

Before being confronted with the cultural differences of Romanian patients during clinical semiology in the 3rd year, foreign students from Romanian university cities already go through several stages of getting along and needing to communicate with individuals who are not only culturally different but also very diversified. There is foremost an immediate medium that is profoundly multicultural, that of they class colleagues. Just at the University of Medicine and Pharmacy from Cluj-Napoca there are students from over 90 countries who come together. Then, the temporary residence imposes from the start negotiation and adaptability for minimal needs: accommodation, shopping, relations with the authorities or with administrative institutions. As a result, assuming

interculturality is not optional, but not intuitive either. The challenges faced are diverse. Leaving aside the relationships with the colleagues who come from different cultures, foreign students enter a several year immersion into the reality of the Romanian society. We present below a typology of Romanians, which is possibly useful for foreigners, even if only to generate its deconstruction. This typology is exhaustive and belongs to psychologist Daniel David and opting for such a reference represented the novelty of the investigations and of professional sampling. The list below presents a possible portrait for Romanians, which has been simplified here due to obvious issues of space:

1. a personality that is usually defensive, centred on negative aspects (e.g. scepticism, misanthropy, pessimism);
2. a behaviour that does not easily respect norms and rules;
3. major reference points: work, family and religiousness;
4. mistrusting people, foreigners or strangers, with the exception of family;
5. using power in a feminine paradigm, characterised by discussions and the search for consensus, which are sometimes burdened by disputes / disagreements;
6. small scores with regards to values such as universalism, benevolence, hedonism, searching for the new and self-determination;
7. the simulation of the importance of Western values in order to create a good impression;
8. contempt, doubt and relativism are lower, while conformism is high, which makes them predisposed to give in to dogmas (in this case religious). (David, 2015: passim)

How can this information be used in a course on interculturality or in an evaluation test? We will capitalize a part of the information in the last section of this study, but for now we can say how such data can NOT be used: lists with ethnic traits should not be encouraged, they cannot be used as a reference point in forming an intercultural position, absolute credit should not be given to sources, negative or positive positions regarding a trait/list of traits should not be demanded, they can at most be discussed within different reference systems.

3.3. Standardised test for evaluating the IC according to the INCA model

As we have elaborated above, the INCA model proposes a standardised test variant that evaluates the level of the intercultural competence. In the following table we have unfolded the structure proposed in the evaluator's Textbook (INCA 1, 2004: 18-39). Each time, an example of an item from the INCA textbook is followed by a personal example of an item adapted to the evaluation of the cultural competence of 3rd year foreign medical students in Romania.

Test for the evaluation of the intercultural competence
1. Biographical information: 14 items of the fill in information type, answers to open-ended questions, an evaluation on the Linkert scale, filling in / expressing one's opinion. *E.g. 1: In what countries have you been so far?* *E.g. 2: How often have you completed the anamnesis of a Romanian patient?*
2. Intercultural profile: 21 statements on intercultural situations. The person being evaluated needs to tick one of the options – Completely applicable / Pehaps applicable / Not applicable. *E.g. 1: When my interlocutors use gestures or words I do not understand, I ignore them.* *E.g. 2: When I hear that a patient dies in hospital, in Romania, I think that he/she is unlucky.*
3. Intercultural encounters: 4-5 scenarios that can arise when a person lives and works away from home or when in his/her environment new, different colleagues appear. For each scenario there are open-ended questions, with the exception of the last one. This is an invariable role-playing game in which the person who is evaluated needs to give indications related to the evaluator's work, the latter playing the role of a colleague who does not know the language of the place well. *E.g. 1: Given that one of the reasons for which you have decided to work abroad is to find out more about a new country and the life there, analyse your options for accommodation. There is no one correct answer, each variant having its own advantages and disadvantages. Arrange the options in the order of preference and then explain your reasons for your first option.* *a) A place in a hostel, with some of your conationals.* *b) With a family from the new city, paying rent.* *c) alone in a small flat.* *a-b-c-..* *The reasons for my choice are the following:* *E.g. 2: You are in semiology. You have a diabetic Hungarian patient who speaks little Romanian and no other foreign language. You have to explain the procedure of daily injecting insulin to him.*
4. a. Text/video: Students watch a short film (with the script visibly written) or they read a text in which two individuals from different cultures communicate. Then they answer questions about the debatable cultural aspects. *E.g. Why is Mr. Wang interested in the family situation of Mr. Parker?* **b. Group role-playing game:** Several participants in the evaluation form a work-group in which they have pre-established roles. *E.g.1: A team of engineers from Great Britain must build a truck with native engineers in a country from the Middle East. Each of them has essential parts of the truck that the other team does not have. Communicate within the group so that to build a truck together.* *E.g. 2: Work in groups of 3 individuals with different religions / without religion. You have a complicated case. A single mother dies after giving birth and her last wish is for you to baptise the child, before the authorities take him/her away. Find together the proper solutions for the religion of the baptism, the person who officiates, the clothing, the ceremonial objects etc.*

4. Conclusions

Unlike other communication competences, interculturality had not been turned into teaching instructions until the last 2-3 decades. Thus, it benefits from teaching and evaluation methods that are less numerous and less validated by institutionally educational experience and results.

Even less so in the case of interculturality within the clinical environment. In this study we have reviewed, with both advantages and disadvantages, the most known grids of evaluation, which would allow one to identify the level of interculturality with foreign medical students in Romania and would stimulate the gathering of skills, knowledge and attitudes that are relevant for a clear and observable evolution. If in scientific terms evolution is found on the highest levels on scales or on the grids of professional criteria, in one's daily behaviour it still means an obvious change from a static vision to a dynamic one, in spontaneous or programmed cultural encounters, and from the lists of identity traits to an open mind, capable to change the paradigm of reading reality according to the interlocutor.

Annexe: The INCA evaluation grid (for the evaluator)

Level ⇨ Competence ⇩	1 'Basic'	2 'Intermediate'	3 'Full'
General profile	The candidate at this level is on the ladder of progression. They will be disposed to deal positively with the situation. Their responses to it will be piecemeal and improvised rather than principled, even though mostly successful in avoiding short term difficulties. These will be based on fragmentary information.	The candidate at this level has begun to induce simple principles to apply to the situation, rather than improvise reactively in response to isolated features of it. There will be evidence of a basic strategy and some coherent knowledge for dealing with situations.	The candidate at this level will combine a strategic and principled approach to a situation to take the role of a mediator seeking to bring about the most favourable outcome. Knowledge of their own culture and that of others, including work parameters, will be both coherent and sophisticated.
i) Tolerance of ambiguity	1T Deals with ambiguity on a one-off basis, responding to items as they arise. May be overwhelmed by ambiguous situations which imply high involvement.	2T Has begun to acquire a repertoire of approaches to cope with ambiguities in low-involvement situations. Begins to accept ambiguity as a challenge.	3T Is constantly aware of the possibility of ambiguity. When it occurs, he/she tolerates and manages it.
ii) Behavioural flexibility	1B Adopts a reactive/defensive approach to situations. Learns from isolated experiences in a rather unsystematic way.	2B Previous experience of required behaviour begins to influence behaviour in everyday parallel situations. Sometimes takes the initiative in adopting/conforming to other cultures' behaviour patterns.	3B Is ready and able to adopt appropriate behaviour in job-specific situations from a broad and well-understood repertoire.
iii) Communicative awareness	1C Attempts to relate problems of intercultural interaction to different communicative conventions, but lacks the necessary knowledge for identifying differences; tends to hold on to his own conventions and expects adaptation from others; is aware of difficulties in interaction with non-native-speakers, but has not yet evolved principles to guide the choice of strategies (metacommunication, clarification or simplification).	2C Begins to relate problems of intercultural interaction to conflicting communicative conventions and attempts to clarify his own or to adapt to the conventions of others. Uses a limited repertoire of strategies (metacommunication, clarification, simplification) to solve and prevent problems when interacting with a non-native-speaker.	3C Is able to relate problems of intercultural interaction to conflicting communicative conventions and is aware of their effects on the communication process; is able to identify and ready to adapt to different communicative conventions, or to negotiate new discourse rules in order to prevent or clarify misunderstandings; uses a variety of strategies (metacommunication, clarification, simplification) to prevent, to solve, and to mediate problems when interacting with a non-native-speaker.

iv) Knowledge discovery	1K Draws on random general knowledge and minimal factual research about other cultures. Learns by discovery and is willing to modify perceptions but not yet systematic.	2K Has recourse to some information sources in anticipation of everyday encounters with the other cultures, and modifies and builds on information so acquired, in the light of actual experience. Is motivated by curiosity to develop his knowledge of his own culture as perceived by others.	3K Has a deep knowledge of other cultures. Develops his knowledge through systematic research-like activities and direct questioning and can, where this is sought, offer advice and support to others in work situations.
v) Respect for otherness	1R Is not always aware of difference and, when it is recognised, may not be able to defer evaluative judgement as good or bad. Where it is fully appreciated, adopts a tolerant stance and tries to adapt to low-involving demands of the foreign culture.	2R Accepts the other´s values, norms and behaviours in everyday situations as neither good nor bad, provided that basic assumptions of his own culture have not been violated. Is motivated to put others at ease and avoid giving offence.	3R Out of respect for diversity in value systems, applies critical knowledge of such systems to ensure equal treatment of people in the workplace. Is able to cope tactfully with the ethical problems raised by personally unacceptable features of otherness.
vi) Empathy	1E Tends to see the cultural foreigner's differences as curious, and remains confused about the seemingly strange behaviours and their antecedents. Nonetheless tries to 'make allowances'.	2E Has the beginnings of a mental checklist of how others may perceive, feel and respond differently to, a range of routine circumstances. Tends increasingly to see things intuitively from the other's point of view.	3E Accepts the other as a coherent individual. Enlists role-taking and de-centring skills, and awareness of different perspectives, in optimising job-related communication/interaction with the cultural foreigner.

REFERENCES

Bennett MJ. A developmental approach to training for intercultural sensitivity. Intercultural Relations. 1986; 10: 179–96.

Bennett, Milton J., (1993) „Towards ethnorelativism: a developmental model of intercultural sensitivity" in: Paige RM (ed.). Education for the Intercultural Experience. 2nd ed. Yarmouth, ME: Intercultural Press, p. 21–71.

Betancourt, Joseph R., (2003) „Cross-cultural medical education: Conceptual Approaches and Framework for evaluation" in *Academic Medicine*, vol 78, p. 560-569.

Betancourt, Joseph R, Cervantes., Marina C., (2009), „ Cross-Cultural Medical Education In The United States: Key Principles And Experiences", in *Kaohsiung J Med Sci*, vol 25 no 9, p. 471-478.

Byram, M. (1997). Teaching and Assessing Intercultural Communicative Competence. Clevedon: Multilingual Matters.

Byram, Michael, Nichols, Adam, Stevens, David, (2001) *Developing Intercultural Competence in Practice*, Multilingual Matters Ltd.

Byram, Michael, Martyn Barrett, Ildikó Lázár, Pascale Mompoint, Gaillard, Stavroula Philippou, (2014) *Developing intercultural competence through education*, Council of Europe Pestalozzi Series, No. 3, Council of Europe Publishing, accesat la adresa URL: http://www.coe.int/t/dg4/education/pestalozzi/Source/Documentation/Pestalozzi 3.pdf.

Cadrul European Comun de Referință pentru Limbi, accesat la adresa URL: http://www.coe.int/t/dg4/linguistic/Source/Framework_EN.pdf.

Crandall, Sonia J., George, Geeta, S. Marion Gail, David Steve Davis, (2003) „Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study" in *Academic Medicine*, vol 78, p. 588-594.

David, Daniel, (2015) *Psihologia poporului român. Profilul psihologic al românilor într-o monografie cognitiv-experimentală*. Editura Polirom, Iași.

Garrett-Ruccks, Paula, (2012) „Byram versus Bennet: Discrepancies in the Assessement of Learners'IC Development" in *Proceedings of Intercultural Competence Conference*, vol. 2, p. 11-33 (http://cercll.arizona.edu/).

INCA (Intercultural Competence Assessment) Project. A Leonardo da Vinci project (2004). *Assessor manual* (INCA 1) & *Assessee manual* (INCA 2). Online: https://ec.europa.eu/migrant-integration/librarydoc/the-inca-project-intercultural-competence-assessment (15/02/17).

Kripalani, Sunil, Bussey-Jones, Jada, Katz, Marra G., Genao, Inginia, (2006) „A prescription for Cultural Competence in Medical Education", in *JGIM*, Volume 21, Issue 10, pp. 1116-1120.

Lenz, Peter, Berthele, Raphaele, (2010) *Assessment in Plurilingual and Intercultural Education*, Language Policy Division, Council of Europe, Strasbourg. (https://www.coe.int/t/dg4/linguistic/Source/Source2010_ForumGeneva/Assessment2010_Lenz_ENrev.pdf).

Lie D, Boker J, Crandall S, DeGannes C, Elliot D, Henderson P, Kodjio C, Seng L., (2008) Revising the Tool for Assessing Cultural Compentence Training (TACCT) for Curriculum Evaluation: Findings Derived from Seven US Schools and expert consensus. Medical Education Online 2008; (https://www.aamc.org/initiatives/tacct/).

Ursa, Anca, Mărcean, Nora, (2016/1) „Imersiune socioculturală şi strategii didactice interculturale în învățarea limbii române de către studenţii francezi", in *Predarea, receptarea și evaluarea limbii române ca limbă străină. Dimensiune a interculturalității*. Editura Universității Petrol și Gaze din Ploiești, Ploiești.

Ursa Anca, Mărcean, Nora, (2016/2) „Developing Intercultural Communication Competence in Foreign Students Attending Medical Schools in Romania", in *Multicultural Representations. Literature and Discourse as Forms of Dialogue*, Iulian Boldea, Cornel Sigmirean (Editors), Arhipelag XXI Press, Tîrgu Mureș, 2016, pp. 218-225.

Wear, Delese, (2003) „Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education" in *Academic Medicine*, vol 78, p. 549-554.