ON THE IMPORTANCE OF INTERCULTURAL COMMUNICATION AND ENGLISH LANGUAGE SKILLS FOR HEALTH PROFESSIONALS

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Abstract: This article aims to draw attention to some aspects of the importance of English language skills consolidation and of intercultural skills formation for medical professionals (physicians, pharmacists, nurses, therapists and other health workers) under the current political, economic, social and demographic developments within the Europe Union and Great Britain. The method of work is primary and secondary source analysis. The primary sources that have been consulted are regulatory documents of the European Union and of the National Health Service (NHS) of Great Britain, while the referred secondary literature consists in seminal monographs and articles of theoreticians in this field, as well as a selection of articles from the British media. The process of test standardization and of the imposing of stricter language testing conditions for medical professionals is described in the first part of the paper, while in the second part there is a discussion of recent globalization developments with the explosion it brought to cultural diversity (through the concepts of multiculturalism and interculturalism).

Keywords: interculturalism, medical communication, English language testing, medicine, health professionals

This study starts from the premise that, at a theoretical level, communication between the patient and the health care professional is part of a larger process of institutionalization of social interaction and rationalization of the medical profession (Gazi et al 2005, 2). Drawing from Habermas's *The Theory of Communicative Action* (1981), which heavily relies on Max Weber's theory of institutionalization in *The Protestant Ethic and the Spirit of Capitalism* (1992), and relying on the research of Mishler (1984), Gazi et al show how "political and economic structures begin to 'colonize the lifeworld' of individuals, providing institutional standards and rules for action which are unquestioned by participants and, due to the social embeddedness of these institutions, are unquestionable", resulting in communication between the medical professional and the patient becoming "an arena in which consensus on the causes, processes and remedies of illness can be reached through dialogue, working directly on the lifeworlds of patients through discourse" (2005, 2).

Current literature that treats the subject of medical professional-patient communication is extensive, consisting in monographs and studies referring to subjects such as protocols for delivering bad news and offering hope, discussing alternative treatments and compliance, or the importance of establishing rapport with the patient[1]. Increasing academic awareness towards the importance of patient-doctor communication is still a rather recent development, dating from the last the decades of the 20th century or from the first decades of the 21st century. While equally drawing from previously mentioned sources, the present contribution aims to shift the viewpoint towards a different paradigm, that of the importance of communication and language skills *within* the community of medical professionals as well,

[1] See, for example, Debra L. Roter, Judity A. Hall, *Doctors Talking with Patients / Patients Talking with Doctors:Improving Communication in Medical Visits*, Praeger Press, London, 2006; John Heritage, Douglas W. Maynard, *Communication in Medical Care. Interaction between primary care physicians and patients*, Cambridge, Cambridge University Press, 2006; Jo Brown, Lorraine M. Noble, Alexia Papageorgiou, Jane Kidd, *Clinical Communication in Medicine,* Wiley Blackwell, Oxford, 2015.

especially in regards to the contemporary cultural diversity of medical professionals in hospitals, clinics, pharmacies, care homes and other medical establishments.

Current trends in globalization and the fact that, in the medical field in English-speaking countries, an increasing number of professionals in medicine, pharmacy and nursing were born outside of those countries makes the covering of language and communication skills necessary in the curriculum of medical schools worldwide. To offer some examples, in the United States, 25% of the physicians are immigrants, according to a contributor to a major American periodical (Fisher 2016), while in the United Kingdom information from the National Health Service based on figures from the Health and Social Care Information Centre (HSCIC) show that 11% of all medical staff and 26% of doctors are not British, as discussed in an analysis in The Guardian (Siddique 2014). In Australia, census data from as early as 2006 shows that 68.9% of health workers were born in India, Nepal, Philippines, Zimbabwe or abroad (Negin et al., 2013). This high diversity among medical professionals represents the reason why doctors, nurses and pharmacists would benefit from skills such as intercultural sensitivity and the ability to speak a foreign language, in this case English, at an intermediate or higher level.

The World Health Organization draws attention to the problem that, because a huge body of medical information is only available in English, most of the inhabitants of the planet, who do not speak English, are deprived from precious sources of knowledge on rare conditions, which, for example, may not be readily available in Arabic or Chinese: "Language can be a barrier to accessing relevant and high quality health information and delivering appropriate health care – an unmet need that is amplified on a global scale" (WHO 2015).

Currently, European Union regulations direct that:

> "In the majority of the Member States, a certain level of linguistic ability is required for workers within the medical sector, being private or public - either per sector or per post through specific legislation covering health personnel, legislation generally applicable to regulated professions or administrative practice. […] The medical professions may include posts such as physicians/doctors, dentists, pharmacists, veterinarians, ergo therapists, nurses, midwives, paramedics, elderly care personnel, dermatologist, certain laboratory professionals and barber-surgeons (Austria, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Finland, Germany, Hungary, Ireland, Lithuania, Poland, Slovakia, Slovenia, Sweden, The Netherlands and United Kingdom). Health personnel appear to be either required to dispose of the required language skills in order to receive admission for practicing a specific profession, or the enforcement of language requirements rests with the employer." (Jensen 2014, 26)

As back as 2011, it was revealed that "Patient and employer complaints about foreign doctors who lack proficiency in a country's official language are prompting a reconsideration of language requirements for doctors seeking to practise within the European Economic Area, which includes all 27 European Union member states, along with Norway, Iceland and Liechtenstein. The European Commission is now conducting consultations on revisions to the existing Professional Qualifications Directive and plans to issue an updated version…" (Villanueva 2011). Surprisingly, in Romania, according to Law no. 95/2006 on Health Care Reform, there was no language requirement at all for the employment of physicians and doctors, which was contrary to legislation in the rest of the European Union member states. Only in 2016 the mentioned law was amended through a Government ordinance with the

introduction of article 410 paragraph 1 stating that the verification of language skills is limited to the Romanian language skills as it is the official language of the state. Currently, according to article 384 of the same law, medical professionals in Romania can take their oath in the Romanian language or in any of the commonly used languages of the European Union.

In the United Kingdom, the General Medical Council's *Good medical practice* guide (2013) states that medical professional "must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK". Stricter language regulations had been introduced since 2013, when cases of mistreatment resulting in patient's death owing to poor English skills had been revealed to the press. The Guardian (2013) mentioned the case of a physician from Germany whose indications resulted in the accidental death of a patient while the doctor was working as an out-of-hours GP and administered a 10-fold analgesics overdose to the 70-year-old victim. After the introduction of stricter language testing regulations for medical professionals, in 2015, it was revealed that 45% of applicants were not able to prove their language skills were sufficient and, in consequence, were denied practice by the GMC (Meikle et al., 2015). More recently, it was revealed that EU law actually protects European doctors working in the UK, which results in this category of medical professionals in Britain being three times more likely to receiving sanctions for mistakes that are owed to poor language skills (Knapton 2016). Consequently, there have been calls that, given the political opportunity for new regulations opened by the Brexit, EU nationals working in the health field in the UK should be required to take the newer and more demanding language tests, as "Patient safety is of the utmost importance, and we expect all healthcare professionals working in the UK to have a good command of the English language" according to sources from the British Department of Health (Knapton 2016).

Excellent language and communication skills are also required in the case of those health professionals who are mostly concerned with research. In the pharmaceutical industry, medical writing has become so specialized that it has developed two distinct branches: *regulatory medical writing* and *educational medical writing* (Albert 2000). As the previously mentioned author points out, writing something down does not guarantee getting a message across from one person to another (Albert 2000, 26) The exigencies of medical writing have grown in accordance with the recent development in the pharmaceutical field and with the arrival of stricter regulation of clinical trials documents, case reports, investigation brochures, patient consent forms, research protocols, and regulatory documents in general. There are also emerging subdomains of medical writing such as marketing focused writing or medical journalism writing.

The recent "rise" of medical writing as a profession is a phenomenon of great interest for the development of communication skills within health occupations. It is also a proof of the necessity and requirement of clear, concise and efficient communication between all the stakeholders within the medical domain. Many linguists would point to Grice's razor and his "These spots mean (meant) measles" example from one of his seminal studies in order to support the exigency that all equivocalness should be avoided in a field of great importance such as the domain of health: "As a principle of parsimony, conversational implications are to be preferred over semantic context for linguistic explanations", i.e. an utterance should always be taken into account for what the speaker/writer means and for what it implies rather than for what it literally means (see Grice 1957 and 1969). One may add that since medical diagnoses, prescriptions or any discussion related to treatment concordance (deciding on a suitable treatment according to the patient's lifestyle or previous experience with different substances or formulations) or treatment compliance have real, immediate consequences in

the daily life of patients, the need for unequivocalness in medical communication becomes even more stringent.

In the mentioned influential article by Grice, the British linguist shows that "In certain linguistic cases we ask the utterer afterward about his intention, and in a few cases (the very difficult ones, like a philosopher asked to explain the meaning of an unclear passage in one of his works), the answer is not based on what he remembers but is more like a decision, a decision about how what he said is to be taken" (Grice 1957, 387). Mutatis mutandis, we would like to draw the reader's attention to a possible parallel between Grice's "philosopher" and the modern medical professional (be he or she a physician, pharmacist, nurse or therapist), who, when facing patient's questions, often has to rethink his medical decision and explain, sometimes in a language that is more familiar to the person who is asking, his original intentions.

Returning to the importance of intercultural communication in the medical field, this term ought to be clarified and an explanation should be offered as to why it is worthwhile to even discuss issues of interculturalism in relation to the medical professions. Interculturalism and multiculturalism are terms that are connected and which are currently in use, often indiscriminately as although both are related to pluralism they designate different notions. The term multiculturalism has been criticized for promoting the separate living of different communities in parallel structures, thus generating suspicion, reciprocated unawareness between different cultures and the waning of collective identities and common values, while also protecting unacceptable minority practices (see Barrett 2013). There exists the notion of "failure of multiculturalism", which denotes mostly the relationship between Western democracies and their Muslim communities. The notion has been made famous by Chancellor Angela Merkel's comment in 2010 that, in Germany, multicultural society has "utterly failed" (BBC 2010) based on views expressed by an important number of members of the German society that they feel threatened by the increasingly large number of immigrants who are allegedly contributing to unemployment. In contrast to the multicultural perspectives towards diversity management, interculturalism is more inclusive and, although the term is not new, it has not yet been conclusively defined. Ted Cantle, in his monograph dedicated to interculturalism (2012), relies on the conceptualization of the term by Meer and Mood (2011), who show that:

> "first, as something greater than coexistence, in that interculturalism is allegedly more geared toward interaction and dialogue than multiculturalism. Second, that interculturalism is conceived as something less 'groupist' or more yielding of synthesis than multiculturalism. Third, that interculturalism is something more committed to a stronger sense of the whole, in terms of such things as societal cohesion and national citizenship" (quoted in Cantle 2012, 142).

In practice, interculturalism means welcoming diversity by combating discrimination, racial or religious hatred and prejudice towards minorities. It is one of the most pressing issues of contemporary society, highlighted even as far back as 2011 in a special report of the Council of Europe, which identified such threats as "rising intolerance; rising support for xenophobic and populist parties; discrimination; the presence of a population virtually without rights; parallel societies; Islamic extremism; loss of democratic freedoms; and a possible clash between 'religious freedom' and freedom of expression" (Council of Europe 2011). The same report shows that, within minority groups in European states, "Discrimination appears to be especially widespread, and to have very harmful effects, in the following areas: employment;

housing; education; *healthcare* (emphasis ours) and social services; and the actions of the police and law courts" (Council of Europe 2011).

In view of the statistical evidence brought forth in the first part of this study, it becomes clear that from an ethnical point of view health workers and patients are very likely to encounter people of different cultural backgrounds (different mother language, religion and nationality) among their colleagues or among the medical staff that treats them. The importance of good language skills in overcoming the challenges of cultural diversity within the field of healthcare cannot be overstated. In a study by Kelsy Lin Ulrey and Patricia Amason (2009) which started from the premise that cultural diversity has become increasingly important, it was found that efficient intercultural communication skills based on cultural sensitivity correlated with reduced levels of "intercultural anxiety", decreased healthcare professional's stress and helped patients in areas with immigrational demographic changes (Ulrey et al 2009). Given the above evidence and arguments, we hope to have succeeded to some extent in drawing attention towards the necessity of integrating efforts for the improvement of medical students' language skills in the greater effort of "diversity management" and intercultural sensitivity education at European level.

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