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Medical language proficiency: A discussion of interprofessional language competencies and potential for patient risk

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ABSTRACT

In increasingly multilingual healthcare environments worldwide, ensuring accurate, effective communication is requisite. Language proficiency is essential, particularly medical language proficiency. Medical language is a universal construct in healthcare, the shared language of health and allied health professions. It is highly evolved, career-specific, technical and cultural-bound—a language for specific purposes. Its function differs significantly from that of a standard language. Proficiency requires at minimum, a common understanding of discipline-specific jargon, abstracts, euphemisms, abbreviations; acronyms. An optimal medical language situation demands a level of competency beyond the superficial wherein one can convey or interpret deeper meanings, distinguish themes, voice opinion, and follow directions precisely. It necessitates the use of clarity, and the ability to understand both lay and formal language—characteristics not essential to standard language. Proficiency influences professional discourse and can have the potential to positively or negatively affect patient outcomes. While risks have been identified when there is language discordance between care provider and patient, almost nothing has been said about this within care teams themselves. This article will do so in anticipation that care providers, regulators, employers, and researchers will acknowledge potential language-based communication barriers and work towards resolutions. This is predicated on the fact that the growing interest in language and communication in healthcare today appears to be rested in globalization and increasingly linguistically diverse patient populations. Consideration of the linguistically diverse healthcare workforce is absent. An argument will be posited that if potential risks to patient safety exist and there are potentials for disengagement from care by patients when health providers do not speak their languages then logically these language-based issues can also be true for a care team of mixed linguistic backgrounds. Members may disengage from each other or adverse events may occur as a result of misunderstanding or other language-based confounds. While the greater goal of the article is to address the issues of medical language across languages, English and medical English are used to illustrate points. Questions will be posed to stimulate thought and identify a need for research. Recommendations include collaboration between the health and language disciplines.

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What is already known about the topic?

- Interpersonal, cross-cultural communication in health care is patient-centered in both theory and practice.
- Patient safety risks exist and adverse events do occur when a patient does not speak the same language as the healthcare provider.
- Medical English, a sub-genre of English for Specific Purpose provides some evidence of challenges faced by health providers in language discordant situations.
- Interest in medical language proficiency is a developing trend.

What this paper adds?

- Medical language assessment and proficiency should be requisite for working in the health disciplines.
- Language discordance in multi-lingual care teams can negatively affect patient outcomes, add risks to patient safety, and contribute to language barriers amongst colleagues.
- Health and language disciplines need to work collaboratively to ensure acquisition of accurate and relevant medical language.
- Research into the effects of limited medical language proficiency in and amongst health and allied health professionals is required.

1. Introduction

In increasingly multilingual healthcare environments worldwide, ensuring accurate, effective communication is requisite. Language proficiency, particularly medical language proficiency is essential. This paper will discuss language and more importantly medical language, the shared language of all health and allied health professions. The purpose is to explore issues of language discordance that can adversely affect patient safety and interprofessional communication. Discussion will additionally include consideration of how proficiency levels can become barriers to assimilation and acculturation into the professional fold by non-native speakers will be included in the discussion. The goal is to draw attention to the need for further research into the challenges of proficiency in medical language in an environment where one's language is not the standard. Some recommendations will be made to facilitate transition of migrating health professionals into new linguistic environments. An overview of the genre of medical English will be used to illustrate key points and demonstrate how the achievements made in that field are transferable to the advanced sub-genre of medical language in *any* standard or official language. The result of globalization is the increased likelihood that members of a care team will find themselves working alongside colleagues who do not share the same mother tongue. This presents challenges to communication interprofessionally as well as between care provider and patient. This in turn has led to a steady rise in the interest by the health professions in medical language proficiency. The notion that knowledge of and a degree of competency in a standard language is sufficient to work within the complex, dynamic world of medicine is arguable. Standard language and medical language are not the same thing. Fig. 1 illustrates this point. While a health or allied health professional would be able to understand that example, a lay-speaker would have difficulty doing so. This would be true whether the reader's first language was English or not. Indeed, a native-English lay speaker would also have trouble deciphering what is written. That is because it is written in medical language. This same argument would be true no matter which language was the standard.

Command of a shared language such as a standard language allows communication when the primary language of those involved is not the mother tongue. However, neither command nor fluency of a standard language guarantees success in specific contexts such as medicine and healthcare. (See Table 1: Key terms for language abilities.) Within such a specific context, skilful communication: standard and medical language proficiency is required. The implications are that actual language proficiency and education, particularly for medical language should be attended to more fully by the health professions (Hull, 2007; Kawi and Xu, 2009). Patient outcomes could be at risk otherwise (Siemsen et al., 2012).

Currently health research and evidence-informed practices related to intercultural, transcultural and cross-cultural communication put the patient first. Here, he or she is of a different linguistic, ethnic or cultural background than the standard or mainstream (Purnell, 2014; Carnevale et al., 2009; Jacobs et al., 2005) The health professions in general have begun to appreciate what the evidence shows: that when there is a mix of languages or a discrepancy in levels of proficiency in the language being spoken in the health-based interaction, the possibility for misunderstanding and the occurrence of errors are not beyond expectation (Siemsen et al., 2012; Robinson et al., 2010). Divi et al. (2007) identified that this language barrier inhibits the care provider's ability to determine signs and symptoms. They recognized that this can lead to diagnostic and treatment errors or necessitate the increased use of other diagnostics procedures to compensate for the language deficits (Divi et al., 2007). Disengagement from the process by the patient can also be expected. For example, Purnell (2014) asserts that when a patient struggles to understand the health care provider who does not have proficiency in the same language (language discordance) or who is difficult to understand (e.g., related to use of medical jargon), the patient may be left in a

At present patient is hemodynamically stable with a regular, narrow-complex tach. Ventricular rate is 158 bpm. Initiating Valsalva in attempt to decrease heart rate.

Fig. 1. Standard language and medical language are not the same thing.