English for Medical Purposes and Academic Medicine: looking for common ground

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Abstract

This paper looks at a single discipline, known as "Medical Communication" within Academic Medicine and Language for Medical Purposes in Languages for Specific Purposes, and offers a brief retrospective of research and educational thinking, with particular reference to the idea of "common ground".

Keywords: English for Medical Purposes, Academic Medicine, Medical Communication, writing research, communicative skills.

Resumen

Inglés con Fines Médicos y Medicina Académica: buscando un "terreno común"

El presente artículo estudia una única disciplina, que recibe el nombre de "comunicación médica", como parte de la Medicina Académica y la lengua con fines médicos en el contexto general de lenguas para fines específicos, y ofrece una breve retrospectiva sobre la investigación y el pensamiento educativo presentado especial atención a la idea de alcanzar un "terreno común".

Palabras clave: Inglés para Fines Médicos, Medicina Académica, Comunicación Médica, investigación escrita, destrezas comunicativas.

Introduction

In the early 1980s, Ray Williams and others, working at Aston, a UK technological university which concentrated then as now on science and

engineering disciplines, made a determined effort to bridge the gap between "Languages for Specific Purposes (LSP)" – what non-native speakers (NNS) get by way of language support – and "Communication Studies" – what native speakers (NS) get. This was at a time when Communication Skills, to use the more common term, was getting off the ground in science and technology disciplines in UK: Aston Civil Engineering students at that time held mock public enquiries as part of their course. The outcome of the Aston initiative was an ELT Document (Williams, Swales & Kirkman, 1984) called *Common Ground*: but the idea was, and to some extent still is, perhaps, ahead of its time.

This paper therefore looks at a single discipline, known as "Medical Communication" within Academic Medicine (AM), and "Language for Medical Purposes" (LMP) in LSP, and offers a brief retrospective of research and educational thinking, with particular reference to the idea of "common ground".

Our experience is that the approach of LSP specialists, though they are normally thought of as working with NNS students, can be comfortably used with NS. We suggest that the central ethos of LSP is its habit of applying the same principles flexibly, to a range of circumstances, paying careful attention not merely to the language of the subject discipline (which is routine), but also its value system (for instance, see Ferguson, 1997), which is less routine: and that dealing with NS learners is simply an application of these principles. Within AM in the UK, of immediate relevance is the UK General Medical Council (GMC) advice for students and teachers colloquially known as "The Values doc".[1]

To exemplify this we draw on our experience of working with "Doctors in Difficulty", as they are called, at the Interactive Studies Unit (ISU) at Birmingham University Medical School.[2]

Looking back: Academic Medicine and the "communications skills" industry

As far as AM is concerned, the whole point of looking at communication is the recognition that there is more to "being a good doctor" than clinical expertise. A reasonable starting-point for formal research into healthcare communication is a remarkable study by Fawkes et al. (1955). Barbara Fawkes was one of the great nurse-educators of the 20th century, This early

paper is a database study (40 recorded conversations) which offers a list of 25 "skills", many of which appear almost verbatim in contemporary lists: "Listen to the patient", "Repeat pertinent words", "Use encouraging expressions such as 'Hmmm' and 'Yes'", and the like. The idea of "communication" consisting in this way of an open-ended list of skills reflects a major tradition in AM.[3] No less ahead of its time is a corpus-based study, as we might now call it, of medical language (Bridge, 1962).

The structure of the consultation was first considered at around the same time, particularly through Byrne and Long's (1976) classic study. Byrne and Long suggested there were six "Phases" to the consultation:[4]

Phase I	The doctor establishes a relationship with the patient.
Phase II	The doctor either attempts to discover or actually discovers the reason for the patient's attendance.
Phase III	The doctor conducts a verbal or physical examination or both.
Phase IV	The doctor, or the doctor and the patient, or the patient (in that order of probability) consider the condition.
Phase V	The doctor, and occasionally the patient, detail further treatment or further investigation.
Phase VI	The consultation is terminated usually by the doctor.

It is easy to see how the LMP teacher could add probable language realisations to each Phase – "Nice to see you" (Phase I); "What can I do for you?" (Phase II); "Can I just have a little listen to your chest?" (Phase III); and so on. Neither author had language expertise, and their work was subjected to a polite demolition job some years later by Eliot Mishler (1984), but it has had enormous influence.

Byrne and Long's (1976) approach resembles a kind of embryonic Genre Analysis and, though the phrase itself has no currency in AM, the concepts of Genre Analysis are often echoed, particularly by Debra Roter through her development of Bales' Interaction Analysis (Bales, 1950). Over the years, Roter has developed the highly-regarded "RIAS" ("Roter's Interaction Analysis System") (see for instance Roter, 2006) which, particularly in the US, is widely used.

The next milestone was the so-called "Toronto consensus statement", published in *The British Medical Journal*. The statement asserted:

> It has been repeatedly shown that the clinical skills needed to improve [communication] problems can be taught and that the subsequent benefits to medical practice are demonstrable, feasible on a routine basis, and enduring. (Simpson et al., 1991: 1387)

The idea that communication matters may seem obvious to readers, but the paper was a watershed. Few Medical Schools in UK and USA took communication very seriously in 1980 – these days they do, or they hit serious problems with their regulatory bodies.

Since the turn of the century, the Calgary-Cambridge methodology (Kurtz, Silverman & Draper, 1998; Silverman, Kurtz & Draper, 1998; see the Skillscascade website) has been widely adopted.[5] The approach involves teaching "skills" said to be of proven effectiveness. From the linguist's point of view, the skills themselves are poorly defined and frequently overlap. But they are eminently teachable. The same is true of Maguire and Pitceathly (2002), a frequently recommended summary.

Finally, in the last few years, another quasi-genre approach has come into increasing use. This is the "SBAR" methodology, first developed in the Armed Forces[6]. The central idea is that, for instance when "handing over" a patient to a colleague, one should firstly describe the "Situation", then offer "Background", give an "Assessment" and make a "Recommendation" (hence, SBAR). For example, "Mr X is on this medication to alleviate his breathing difficulties. He has a long history of problems connected with asthma. The immediate problem is improving slowly. I recommend his medication is reviewed at 4 pm".

Looking back: Academic Medicine and writing research

AM has a high level of engagement with issues of language. In UK the process has been helped by the fact that the two leading UK-based generalist journals in the field have had highly literate editors: Richard Smith at the *British Medical Journal*, and Richard Horton at *The Lancet*.

A major theme of AM writing-about-writing is the inevitable focus on the risk of fraud. An excellent starting point is a paper written by Horton for Smith's *BMJ* (Horton, 1995). Horton begins: "Be careful when reading this article. My purpose is to persuade", and goes on to discuss "hyperbole", and peer review, which:

> (…) frequently ignores a factor that, to the doctor or scientist, may be thought too trivial to devote much attention to: the manipulation of language to convince the reader of the likely truth of a result. (Horton, 1995: 985)

Since leaving the *British Medical Journal* Smith has produced an exhilarating book, called *The Trouble with Medical Journals* (Smith, 2006) which is about – well, just that. Amongst other things, peer review is a particular source of irritation for him, too: "it is slow, expensive, ineffective, something of a lottery, prone to bias and abuse, and hopeless at spotting errors and fraud" (Smith, 2006: 8).

As much of this brief overview of AM and LMP implies contrasting approaches to research, it is worth quoting Smith's standpoint. He is no reductionist: as his book makes clear, he admires Thomas Mann, which hardly suggests a low tolerance of ambiguity. Nevertheless:

> I'm suspicious (…) of ideas that are supposed to be so profound and complex that they cannot be expressed in language that everyone can understand. There may be such ideas, but I don't know any. (Smith, 2006: 5)

The biggest change in AM research in recent years has been the rise of Evidence-based Medicine (EBM), which has set up more and more precise specifications both for the conduct and reporting of research trials.[7] Whether misrepresentation or fraud can be controlled by battening down the structural hatchways like this is an interesting speculation.

Looking back: Language for Medical Purposes

The story of AM, then, is that "good communication" is something all doctors need. And research into both spoken and written communication has moved towards a kind of unacknowledged, but often sophisticated, form of GA, coupled by skills lists which carry conviction within the field, but lack linguistic coherence.

Within LSP, healthcare was one of the earliest testing-grounds for the Sinclair-Coulthard school of Discourse Analysis (see for instance Bruton, Candlin & Leather, 1976). The mid-1980s saw some excellent book-length studies with a generally anthropological or sociological flavour to them: Mishler (1984) has already been mentioned, but there are also West (1984), and Fisher and Todd (eds.) (1983).

Salager-Meyer, one of the leading figures in LMP (see in particular the "Medicine and Language" section of the Elsevier *Encyclopedia of Language and Linguistics*, which she edited in 2006) also gives a fascinating historical account of some aspects of medical writing (Salager-Meyer & Defives, 1998; Salager-Meyer, 1999). In terms of the more recent past, Maher's (1986: 113) excellent review argues for "a recognition of the combined sociological and linguistic character of language learning".

Another study from the 1980s still cited is Prince, Frader and Bosk's (1982) early work on hedging. It is worth noting that of these three distinguished academics, Prince is a linguist, Frader a paediatrician with considerable expertise in Medical Humanities, and Bosk a sociologist and medical ethicist.

For written LMP, there is – inevitably – work on the research article (RA). Li (2009) gives an account. But the field has also, increasingly, moved beyond the RA, and in doing so has moved towards a level of rapprochement with AM. As regards methodology, there have been a few studies which have used corpus-based techniques to look, for example, at doctor-patient interaction (Skelton & Hobbs, 1999), and the language of teenagers on a health advice website (Harvey et al., 2007). As regards topics, Tipton (2005) for example, in a special issue of *Journal of Applied Linguistics* edited by Sarangi and Candlin, looks at case presentations, building on Anspach (1988) and Cicourel (1999), and describes a course in the area for International Medical Graduates (IMGs).

An interesting recent development has been the way that EMP has reflected contemporary trends in Medical Education, and sought to build them into courses – see Belcher (2009) for a rationale. There has been a movement in Medical Education since the early 1970s towards Problem-based Learning, or PBL (see for instance Neufeld & Barrows, 1974; Barrows, 1996). There have been many linguistically relevant studies here, and an issue of *Discourse Processes* (Vol. 27, no. 2, 1999) was devoted to it. Legg (2007), for example, reports on the way that English Language support for medical students in Hong Kong undertook a genre analysis of PBL tutorials. She quotes Frederiksen (1999: 137): "Participants must be able to understand the reasoning process as it is unfolding through the discourse of interaction" (Legg, 2007: 344).

Wood and Head (2004), in a study based in Brunei, make a similar point:

> It is proposed that such an approach can not only teach the kinds of processes that are traditionally taught in EAP, but also … [foster] the kinds of learning and study skills that PBL develops.

The relevant thing here is the clear understanding that "teaching the language" is a means, not an end.

As regards teaching materials, that much-used textbook, easily the best-known in the field (Glendinning & Holmstrom, 1987), has always had close links with medical specialist informants – and it shows. The Tokyo Medical University website[8] offers free access to a wide range of interesting materials and Hoekje (2006) offers an excellent description of contemporary practice.

Beyond that, there is a better understanding within AM of the challenges IMGs and NNS medical students face. Hoekje and Tipton (eds.) (2011) provide a very useful overview of key issues, as does Eggly (2002). Roberts and colleagues (see for instance Roberts et al., 2000 & 2005) have made contributions of some influence within AM.

This returns us to the starting point. If the aim of LSP is to be centred on the purposes for which language is used, then the need to work across disciplines is central. Roberts and Sarangi (2003) offer an account of their own consultancy with the Royal College of General Practitioners (RCGP); they conclude, unsurprisingly, that one must try to bridge the gap, and that it is hard.

It is an unfortunate irony perhaps that papers about bridging the gap can be heavily skewed towards abstract theorising of a kind viewed with suspicion in AM.

The present: The professional self and common ground

The point we began with, that the "good doctor" is more than just a mechanic of the body, has come to assume overwhelming importance. We shall discuss this in a UK context, since we know this best, but see also the US initiative from the mid 1990s, "Project Professionalism".[9]

Within the UK, the two driving factors have been the repercussions from the Shipman affair[10] and the enquiry into the problems at Bristol Royal Infirmary (BRI).[11] Shipman was a British GP who murdered an unknown number, but

certainly several hundreds, of his patients. The appalling nature of his crimes forced a reappraisal of the concept of "fitness to practise" – of who should be allowed to be a doctor. Shipman after all passed his exams. The BRI affair involved the sub-standard care that very young children with serious heart problems received at one UK hospital. The government enquiry, known as the Kennedy Report, was crucial in changing the UK environment. Of note is its authoritative, and beautifully written, introduction.

In consequence, it was suggested, there was a need to "broaden the notion of competence". Six areas were suggested:

Area 1. Skills in communicating with patients and with colleagues;

Area 2. Education about the principles and organisation of the NHS, how care is managed, and the skills required for management;

Area 3. The development of teamwork;

Area 4. Shared learning across professional boundaries;

Area 5. Clinical audit and reflective practice;

Area 6. Leadership.

These six areas form the backbone of the work we do. "Communication" (and language) are part of the overall development of the responsible professional, who is a reflective practitioner with an awareness of the workplace environment, and uses language to achieve professional goals within it. Within AM, professionalism is the term used, and it is now a central issue. The leading names in the field are Stern and Papadakis, and their *NEJM* paper (Stern & Papadakis, 2006) summarises the issues well. Note too that *The European Journal of Internal Medicine* recently (2009) ran a special issue on the topic.[12]

We turn now to the work that we undertake with doctors (and a few dentists) who are referred to us for remedial support.

Working with "Doctors in Difficulty"

These individuals are inevitably referred under the label of "communication difficulties", but this phrase can cover more or less any of the six areas identified above. In the great majority of cases, the apparent deficiencies

result from a range of underlying problems: they tend not, in themselves, to "be" the problem. We exemplify this below with reference to four distinct cases, anonymised and with a couple of non-significant details altered for the purpose of confidentiality. All doctors work with us on a one-to-one basis.

In UK there is a national Doctors in Difficulty programme to support qualified doctors who are still in training.[13] It differentiates between "trainees IN difficulty", "trainees WITH difficulties" and "difficult trainees". These are defined, respectively, as those failing to progress satisfactorily (mainly via assessment hurdles), those facing shorter term problems such as family health issues or moving house, and thirdly those whom others find it hard to work with. It is rare for us to encounter a doctor who does not fall into at least two of the above categories.[14]

Two assumptions are often made in UK about doctors with communication difficulties. One is that they are likely to be speakers of a first language other than English. Secondly, and by implication, they are likely to be International Medical Graduates (IMGs). Indeed, 73% (24/34) of trainees referred in 2009, for example, were IMGs, 65% (34/52) in 2010. But such figures are not particularly helpful. They include non-UK graduates who are monolingual English speakers (Irish, say), for example. On the other hand, we see UK graduates who are not native English speakers (for instance, Hong Kongese) and UK graduates who are multi-lingual or bilingual (for instance, British Asian), as well as monolingual UK graduates. Beyond that, we also encounter Doctors in Difficulty from much more complex backgrounds.

In fact, we are faced with four typically conflated issues: language background, current/previous citizenship, perceived/self-identified ethnicity and place of graduation. What is important is that we are able to work with them in essentially the same way, merely shifting the focus towards or away from "LMP issues" depending on the doctor.

We are less frequently asked to work on a doctor's doctor-patient communication than on communication with colleagues. This touches closely on areas such as "teamwork" and "leadership" in obvious ways, and a lot of what we do comes under the general heading of "interactive management", particularly given the current emphasis in AM on the "multi-disciplinary team" (MDT) – junior and senior doctors, nurses, theatre operatives, etc.

In the example cases that follow we have endeavoured to show a typical range of the referral issues we come across on a fairly regular basis and also how we approach remediation issues. Success depends on insight and an acceptance that the doctor has responsibility for reflection and, as appropriate, change.

The actual training process is typically as follows. There is a preliminary meeting with the doctor to assess educational needs (and often, also, to allow the doctor to put his or her own case – perhaps that the potentially stigmatising label of "doctor in difficulty" is unjust). This is followed by a number of one-to-one sessions, often working with a simulated patient who takes the role of a patient or colleague, so that the doctor can practise in a rich-context simulation.

Occasionally, then, a referral may appear very straightforward with communication issues focussing purely on language delivery. This can be illustrated in our first case, Dr.A.

Dr. A: "Just" language skills?

Dr. A possessed a good level of English, although with a strong accent, affecting both segmental and suprasegmental pronunciation. She was as a result sometimes difficult to understand. This therefore raises serious issues of patient safety.

Note that most IMGs have to demonstrate ability in English before being allowed to practise in UK. The normal route is through IELTS (band 7), followed by further tests (known as "PLAB"), where "communication" forms part of a wider clinical assessment.

Her problems define her as a "difficult trainee", additionally, appraisal concerns could lead to "a failure to progress satisfactorily". Her willingness and enthusiasm to remedy problems was apparent throughout her two meetings.

Strategies adopted, however, sometimes worked against her. A good example concerns initial advice to break up the flow of her delivery as a way of giving the listener a little longer to process what she was saying. In the second session there was an element over overcompensation, with significant pauses following the simulated patient's answers, leaving the latter rather "unsettled", in his words. A pause to assist the listener's understanding, in other words, had lengthened into a slightly embarrassing silence.

This overcompensation extended into other aspects of Dr. A's interaction – both in terms of language and behaviour. She was encouraged to consider the effects of her rather exuberant body language and vocal delivery on her patient, as well as her over-hastiness to rephrase her utterances, often unnecessarily, in her endeavour to make information accessible. Her doubts about her language use were in a sense often unfounded, as temporary confusion came often from misplaced word stress only rather than choice of lexis – though the effect was, nevertheless, that it was a struggle to understand her.

Our job here then was not to coach her purely in "use of language" but rather to develop her own insight into the effects of her language strategies and make minor adjustments from gauging patient and colleague reaction. However, despite Dr A's intelligence and eager co-operation with the training process, there were issues of insight. She perhaps came to us expecting us to offer "English lessons". And, while there was a clear need to improve her pronunciation, what was principally at stake was emphasising the need for reflection on her performance, and as far as we were able to do so, giving her a vocabulary to reflect with. This is a constant theme in our work, and is also central to Problem-based learning as it is practised in AM, and briefly described above.

Dr B: Using language as theory

Dr. B, although also an IMG, came with a different agenda. His annual review of training had recommended additional training in communication and teamworking.

Here, by category definition, was a "doctor in difficulty", failing to progress satisfactorily. He was a competent speaker of English. By implication then, the issues labelled "communication" (that is, communicating with colleagues) would appear to be not language problems, but arising as a direct result of problems cited with teamworking. However, a 360º appraisal exercise (such appraisals are very common, and consist typically of 8 to 12 colleagues offering confidential comments) subsequent to the review offered no evidence at all of problems with colleagues. Confidential discussion revealed a very difficult relationship with a senior closely involved in his training. This matters because a team where not all members are on effective speaking terms is a team which poses a risk to patients. There had been a variety of strategies undertaken to repair this one problematic relationship,

without success, and this was beginning to impact on the doctor's health and well-being.

This is a good example of an initial category of difficulty extending into a more complex area of concern. Supporting the doctor was a sensitive process, not least because it seemed likely that the senior doctor was in large part responsible for the "difficulty". Discussion, however, enabled us to explore in some detail the nature of repair strategies attempted at different points, not from the point of view of actual language used but from a wider appreciation of the style of talk and behaviour adopted. As we have done with a wide variety of doctors, we introduce the doctor to basic Speech Act Theory. This allows a framework for discussion of the difference between the intended purpose of the speaker and perception of the hearer.

For example, it seemed there were cultural issues: Dr B's own culture had different, more overtly deferential, ways of demonstrating respect to senior colleagues, for instance. We suggested, therefore, that a lengthy silence in response to a challenging remark may have been intended as respectful acceptance, but perceived as resentment, or inappropriately submissive. Similar dilemmas may have resulted from attempts to justify actions, which could be perceived as being anywhere on a continuum between appropriate confidence and disrespectful arrogance.

Here then, the remediation strategies, though in one sense obviously drawing on expertise in linguistics, followed lines which would have been equally appropriate in working with native speaking professionals in any field.

Dr C: UK-born doctors: attitude driving language

Dr. C was a (Caucasian) British doctor, UK educated, with a clear communication problem, occurring with patients and families. She was not a trainee.

Dr. C was essentially a doctor "with difficulties", for various reasons. Most notably these featured her own previous, serious illness and career development. She did in fact show insight into how her consulting style was unsettling to patients, in that her rather business-like, no-nonsense approach often made them feel, to pick up this word again, "depersonalised". This may be a strength in other medical contexts, most obviously in the SBAR-style swift, concise, confident clinical handover valued in hospitals, and Dr. C perceived her abruptness as being efficient.

Basic "language" choices made were more problematic with Dr. C than with the doctors discussed so far, resulting in the role-player feeling at times "taken aback" by comments which were perceived as confrontational or, at best, dismissive. Occasionally, an attempt at humour would misfire: she told us of a patient who had said "I want to stop taking those tablets because my skin was awful before". Dr. C responded, it seems "Well, it is now!". Quite: one can see why this might not work.

Underlying everything with Dr. C was a sense that her previous serious illness had made her intolerant of patients with ostensibly minor problems, such as the skin condition above. The question was therefore first and foremost one of the doctor's attitude. Did she perceive the real issue? If so, did she have the motivation to change? And if she did, would she work to improve her interpersonal skills and language choices?

Conclusions

This paper is a reflection on two separate research and educational traditions which have developed more or less independently. On the other hand, it is also intended to be a reflection on how much "common ground" there is, both at the level of research, where the traditions have felt their way towards a broadly genre-based approach, and also at the level of education.

As regards educational interventions in particular, we have tried to show, with the doctors we discuss, that there is no clear divide between those with language problems *tout court* and those with professional problems which surface in language use.

We would argue that if "communicative competence" means anything in the professional context, it means the development of a professional persona which is, and can project itself as, honourable, competent, committed, and so on. And, beyond that, the aim is to help students develop the resources they need to self-monitor and reflect.

The strengths of the LMP tradition over the last 30 years are the expertise it has brought to bear on textual analysis. Its central weakness is, inevitably, that it has not always understood medical values. For all the work on the RA in medicine, for example, there is little evidence of an understanding of the epistemology rather than the language.

In this respect, there has been recent debate (Upton, 2012) on the merits of a "wide-angle" and "narrow angle" approach to LSP. The issue is, in an educational world of limited resources, how "specific" can one be? Well, the more specific the better of course. But we would argue also that an understanding of the general ethos of LSP is central, since it is this which guarantees the willingness to work with flexibility, and to make the imaginative leap, as necessary, into the value system of the learner.

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NOTES

[1] General Medical Council (GMC) ("The Values doc"). URL: http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp [08/05/12]

[2] See URL: http://www.isu.bham.ac.uk [08/05/12]

[3] See the Calgary-Cambridge model at URL: http://www.skillscascade.com/handouts/ccguide1.htm [08/05/12]

[4] For this and other "models of the consultation", as they are commonly known, see URL: http://www.skillscascade.com/models.htm [08/05/12]

[5] For a detailed critique, however, see Skelton (2008).

[6] National Health Service SBAR. URL: http://www.institute.nhs.uk/quality_and_service_improvement_tools/ quality_and_service_improvement_tools/sbar_-_situation_-_background_-_assessment_-_recommendation.html [08/05/12]

[7] For an introduction, see the Bandolier website ("Evidence-based thinking about healthcare" at URL: http://www.medicine.ox.ac.uk/bandolier/ [08/05/12]. For issues around the reporting of trials see the Consort Statement website at URL: http://www.consort-statement.org/ [08/05/12]

[8] See URL: https://www.emp-tmu.net/ [08/05/12]

[9] To learn more about "Project Professionalism" from the American Board of Internal Medicine at URL: http://www.abimfoundation.org/Resource-Center/Bibliography/~/media/Files/Resource%20Center/Project%20professionalism.ashx [08/05/12]

[10] See the reports which arose from the Shipman Inquiry 2002-5 at URL: http://www.shipman-inquiry.org.uk/reports.asp [08/05/12]

[11] For which see The *Bristol Royal Infirmary Enquiry* (2001), also known as "The Kennedy Report" at URL: http://www.bristol-inquiry.org.uk/final_report/report/index.htm [15/05/12]

[12] The *Journal of Internal Medicine* is an imprint of Elsevier and can be found at URL: http://www.journals.elsevier.com/european-journal-of-internal-medicine/ [02/08/12]

[13] Doctors worldwide are normally regarded as "trainees" for ten years or more after their medical degree.

[14] Note that we also see doctors "*not* in training", many of whom refer themselves.