Medical student and patient language congruence: Impact on clinical learning and communication

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Abstract

Language congruence between practitioner and patient is a key influence on clinical communication. It influences not only the quality of communication in terms of information transferral but also the capacity of practitioners to establish rapport and maintain culturally-appropriate interactions.

This article reports on a qualitative interview study using thematic analysis conducted with final-year medical students of Monash University's Jeffrey Cheah School of Medicine and Health Sciences in Malaysia. It investigated their perceptions of how the different languages used in communicating with patients influenced clinical interactions, as well as the nature of their learning within the clinical environment. Within the clinical learning settings investigated, many of the students and patients were multi-lingual, and both the students and patients varied considerably in their proficiency in the national language, Bahasa Malaysia, as well as in English.

The study found that students perceived that the language used for consultation influenced clinical communication in a variety of ways, including the capacity to establish rapport, the approach to questioning, the amount and type of information elicited from patients and the ability of the students to express ideas and information with sensitivity. In turn, these factors had an impact on clinical learning, influencing, for example, patient expectations and behaviour. In some cases, particularly where there was a lack of alignment between perceived shared ethnicity and language congruence, it even had an impact on medical student "access" to patients. The paper explores some implications of these factors for clinical learning.

Introduction

It is self-evident and widely accepted that the languages used in consultation, along with the health literacy of patients, influences the effectiveness of clinical communication (Chwan-Fen & Gray, 2008; Manderson & Allotey, 2003; Roberts, Moss, Wass, Sarangi,

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& Jones, 2005; Sudore et al., 2009). There are dramatic examples within the literature of how communication difficulties due to language differences between practitioners and patients have resulted in serious medical consequences (Fadiman, 1997; Galanti, 2008). On a day-to-day basis, less dramatic incidents and issues around language and cultural differences lead to miscommunication, confusion or tension between practitioners and patients (Roberts et al., 2005; Street, Gordon, & Haidet, 2007; Teusch, 2003). The increasing focus on cultural competency within medical courses is at least in part in recognition of the potential impact of clinical communication on health outcomes (Dogra & Karim, 2005), whether directly or indirectly.

This study explored, from the perspective of final-year medical students, how the language used to conduct clinical interactions influenced the nature of the communication, and it considered some implications of this for learning. In the Malaysian context investigated, English was widely spoken by clinicians, although Bahasa Malaysia (the national language) was the most common language used for consultations with patients; however, a significant number of patients spoke neither English nor Bahasa Malaysia, or only very little of one or the other. These patients preferred to communicate in their first languages (e.g., Tamil, Mandarin Chinese, Cantonese). Similarly, many of the medical student participants had varying levels of proficiency in several languages—this meant they could communicate to some degree in a variety of languages but had preferences as to which language(s) they felt most effective and comfortable using within a clinical context.

Malaysian clinical context

The Malaysian clinical environment is complex in terms of communication. The Malaysian hospital and clinics where participants in this study did most of their clinical learning are public institutions that serve primarily lower socio-economic patients from a range of linguistic and cultural backgrounds. Both practitioners and patients frequently participate in medical interviews and interactions using a second or other language. Proficiency levels vary considerably. It is not uncommon for Bahasa Malaysia to be used as a common language, despite it not being the first language of either the practitioner or patient. Conversely, practitioners who are fluent in Bahasa Malaysia may regularly be required to use English or another language as a common language for communication with patients. Medical interpreters are not commonly available, and often hospital staff and patients' relatives act as interpreters. The experiences of participants in this study need to be viewed within this particular context.

In addition, the politics around language use are complex in the Malaysian context. While this aspect is beyond the scope of this paper, it is appropriate to acknowledge that it may account for some patient attitudes and behaviours as reported by the students interviewed, as well as potentially influencing student perceptions and responses.

Method

This qualitative interview study using thematic analysis (Miles & Huberman, 1994; Silverman, 2011) sought to explore the clinical learning environment from the lived experiences of the participants (all final-year medical students) based on socio-cultural learning theory, which views learning as "an activity involving increased access to participating roles in expert performance" (Bleakley, Bligh, & Browne, 2011, p. 55). According to this view, the context in which learning occurs is fundamental, and learning is "situated" and both "social and cultural in character" (Bleakley et al., 2011, p. 45).

The study was conducted at Monash University's Jeffrey Cheah School of Medicine and Health Sciences in Kuala Lumpur, Malaysia, and involved semi-structured interviews. Participants were all Monash University final-year medical students based in Malaysia, and all final-year students across two cohorts were invited to participate. Participation was voluntary, and consent was obtained from all participants. Some students chose not to participate, while others were simply unavailable at the time of interviewing. The study was approved by the Monash University Human Research Ethics Committee.

Out of a total of 84 Year 5 medical students (46 in 2009 and 38 in 2010), interviews were conducted with 58 (32 in November 2009 and 26 in November 2010). Forty-seven participants were Malaysian, and 11 were international students from Singapore, Mauritius, Sri Lanka and Indonesia. Malaysia is a highly diverse society in terms of both language and culture, with the three dominant ethnic groups being Malay, Chinese and Indian. The Malaysian participants reflected a broad cross section of Malaysian society in terms of culture, ethnicity and first language background. Where the ethnicity and/or first language of a participant was considered relevant in interpreting the interview excerpts presented, this information has been included.

All participants in the study had completed the bulk of their clinical learning at Hospital Sultanah Aminah in Johor Bahru, and had also completed a minimum of two clinical rotations at Australian hospitals, mostly in Melbourne. Approximately 35% of the participants nominated Bahasa Malaysia as their first language, a significant number spoke Bahasa Malaysia as a second or other language to varying degrees of proficiency and a minority had no or minimal proficiency in Bahasa Malaysia. Of the participants who nominated their ethnicity as Malay, several nominated English as their first language.

Interviews were conducted in English by two interviewers, one Malaysian (CC) and one Australian (JH), at the Johor Bahru Clinical School of Monash University. The interviewers were both language and learning support staff based in Kuala Lumpur and Melbourne, respectively. Although known to most of the students interviewed, they were not involved in the students' clinical learning or in any aspect of their assessment. All interviews were digitally recorded, and handwritten notes were taken by the interviewers. Some demographic information (e.g., nationality, first language, self-identified ethnicity) was obtained at the commencement of each interview.

The interviews conducted with participants spanned a range of topics, some of which may be reported on in a subsequent paper; however, there were two specific questions related to language use, and responses to these formed the particular focus of this paper. These questions were:

1. Does the language you are using affect your interactions with patients? How? Give specific examples.
2. Do you employ the same approach to clinical communication regardless of what language you are using? If not, please elaborate.

The researchers individually conducted initial analyses of the digital recordings and interview notes to establish broad categories. Significant passages within the digital recordings were identified and transcribed. Interview notes and transcriptions were de-identified, but some demographic information (e.g., nationality, first language, self-identified ethnicity) was retained for comparison purposes. Then, through an extended process of further analysis and discussion, the researchers collectively identified several key themes emerging from the data.

Results

In responding to the two language-related questions, the students considered both the languages used by patients and the languages used by themselves as student doctors.

The following themes were identified from the data relating specifically to the two interview questions on language use outlined above. These themes reflect views expressed consistently by significant numbers of participants across both years in which interviews were conducted.

Creating rapport/expressing empathy

The students interviewed reported feeling more able to create rapport when using their first language. They felt more able to use appropriate language and control their influence on the interaction:

> *In Bahasa Malaysia … more comfortable, more effective, easier to create rapport …* (Malay student—Bahasa Malaysia first language)

> *I think if you conduct in Malay* ***they will feel kind of friendliness*** *… because sometimes you will use the [colloquial] language that they use in the society … so they will understand it better.*

The students also felt that they could be more sensitive and effective in their questioning and interaction when using their first language. For example, some Bahasa Malaysia first language speakers noted difficulty, when on placement in Australia, showing empathy appropriately in English when this was required.

> *To me it's a lot easier to conduct the interview using my own language … The disadvantage of using English is that sometimes* ***it's hard for me to express my question or my empathy*** *… so by conducting the interview in Bahasa [Malaysia] I … can be a lot* ***more friendly and sympathetic to the patients****.*

Expressing ideas with sensitivity in a second or other language

Although the students generally considered their English language proficiency levels to be adequate for their placements in Australian hospitals and functional for gathering information, they noted difficulty when required to phrase questions with sensitivity. They sometimes feared that when addressing sensitive topics, their questioning could be perceived by patients as impolite or insensitive.

> *In terms of constructing a good polite and respectful sentence to the patient maybe that's quite difficult [in English, when in the Australian hospitals] … for example, if I want to ask about sexual activity,* ***it's quite difficult to make it polite and not disturb the patient's feelings.***

Patient more "open" when communication is in patient's first language

> *… if you speak in Malay [as opposed to English] people* ***tend to be more open to you*** *… it seems like more of a story than [just] happened, what happened, what happened …* ***they tell you a long story*** *with [more information] … especially if the patient is Malay.*

It was evident that students perceived that patients were more relaxed and comfortable when interacting in their first language. This not only made establishing rapport easier but also was perceived to have positive benefits in terms of the quality and volume of information volunteered by patients. The students reported that patients seemed to more openly provide information, be more likely to *volunteer* additional information, and be more willing to *elaborate* when asked:

> *I find that when I try to speak in Tamil [patient's first language], patients are* ***more friendly, they will open up more****, and they like … they prefer to speak in their own native language rather than speaking in Bahasa [the national language] … they'll tell you things even they don't tell the consultants.* (Malaysian Indian student—Tamil speaking)

Adapting language to the cultural and healthcare context

One student discussed in some detail how his approach to communicating with patients varied depending on culture and language. In particular, he felt that the approach he adopted with Australian patients, when on placement in Australia, may not necessarily be appropriate or effective with patients from his own familiar Chinese Malaysian culture:

> *It's not so much about language but more about the culture that would result in me changing my approach …* ***How I explain something to a Caucasian would definitely be different to how I explain something to a Chinese****. … that's due to the inherent cultural differences … you need to understand how each culture work [sic] to be able to speak their language in a sense … by doing that* ***they would actually be more receptive*** *to what I have to say.* (Malaysian Chinese student)

A number of students noted that they tended to adapt their communication style to suit expectations in the different locations in which they completed clinical placements. They felt that although their curriculum presented a particular recommended approach to clinical communication, based largely on Australian patient-centred norms, approaches

particularly effective in the Malaysian clinical context were also modelled for them in their learning environment. Therefore, they felt able to adapt and vary their approaches when required to meet the needs of patients in both Malaysia and Australia. In addition, several expressed a view that the clinical communication approach introduced in their course, which emphasised patient-centred, collaborative interactions, was greatly valued by many patients in both Malaysia and Australia, despite not necessarily being suited to all contexts.

Patient assumptions about the language for consultation

An interesting theme consistently raised by the students was patient expectations and assumptions about what language would be used for the clinical interaction. This was particularly an issue for students who were not necessarily proficient in the language commonly used by the ethnic community to which they belonged or were assumed to belong based on their appearance. For example, some Malaysian Indian students were ethnically Tamil but not proficient in the Tamil language; therefore, they conducted clinical interactions in English or Bahasa Malaysia, languages in which they were proficient. This sometimes created issues when they were interviewing or examining Malaysian Indian patients who were Tamil speakers, with a preference to communicate in their first language:

> *Some of the Indian patients can't speak Malay well, or English very well, so* ***they expect me to speak to them in Tamil*** *… and my Tamil isn't very good so I can't really speak to them with their language … sometimes they just* ***refuse to speak in other languages*** *with me, or they'll get angry with me like "shame on you" … they will think I don't want to speak in my mother tongue …* ***they will just make those sorts of assumptions****.* (Malaysian Indian student)

Similar issues were reported by Malaysian Chinese students, some of whom were not proficient speakers of Chinese or only spoke a dialect different to that of their patients:

> *No problem with the Malay patients … they like it when you can speak their language well … Honestly, I had difficulty with the Chinese patients … I speak Cantonese but they speak Mandarin [in Johor Bahru] … the problem is,* ***although the Chinese patients can speak Malay, they refuse to speak Malay to a Chinese*** *… you will definitely get scolded …* ***so I try to avoid Chinese patients****.* (Malaysian Chinese student)

As in the above quotation, these issues sometimes had an impact on the learning environment, creating a situation where students reported avoiding patients from their own ethnic background in order to limit potential difficulties around the choice of language for interaction. They reported that it also impacted on the level of rapport and cooperation they were able to establish with patients in such cases, leading sometimes to a less harmonious and cooperative interaction, sometimes involving patient frustration or even hostility.

Table 1

Language Spoken by the Medical Student

Interacting in student's first language	Interacting in a second or other language
• More capacity to use colloquial language • Able to understand responses to open-ended questions • More able to express ideas sensitively • Greater awareness of cultural sensitivities • Greater register flexibility (movement between formal and informal registers)	• Less ability to explain • Less able to "educate" patient • Less capacity to express ideas sensitively • Tendency to use closed questions (to confine the patient responses) • Reliance on "street language" rather than a more formal language register

Table 2

Language Used by the Patient

Interacting in the patient's first language	Interacting in a language other than the patient's first language
• Patient engages more readily—easier to establish rapport • Patients more able to respond to open-ended questions • More information volunteered—patient "opens up" and reveals more • Patient more friendly and relaxed	• Patient more "closed"—less likely to volunteer information or elaborate • Shorter responses

Summary of results

The preceding tables outline some common student responses. Table 1 presents common responses regarding how the language used by these medical students influenced their medical interviews and clinical interactions with patients. Of note is that many felt less able to use open-ended questions when communicating in a second or other language and less able to express ideas with sensitivity and subtlety.

Table 2 refers to student responses regarding how the language used by the *patient* influenced the medical interviews and clinical interactions. As may be expected, patients appeared more relaxed and engaged when communicating in their first languages and more willing and able to volunteer information and elaborate.

Discussion

Clearly, a significant variable influencing student experiences and responses was their degree of proficiency in the various languages in which medical interviews and clinical interactions were conducted. Some were effectively bilingual in English and Bahasa Malaysia, or bilingual in English and another community language. However, most reported feeling able to communicate most effectively in their first language, having some capacity to communicate in other languages with varying degrees of proficiency as well as having a good level of proficiency in English. Similarly, patient language proficiency in the range of languages used in the clinical setting also influenced patient behaviour.

The students interviewed agreed that patients appeared more receptive, more expansive and more relaxed when interviewed in their first language (as indicated in Table 2). This is not surprising, particularly since for most patients, it was also the language in which they were most proficient. However, the assertion by Robert et al. (2005) that language and culture are largely inseparable in how they influence clinical encounters may also be relevant here. According to Gray (2008), "the ideal is for people to receive care from people of their own culture, and … the next best option is for people to receive care from a carer who has a deep understanding of their cultural background" (p. 125), which he suggests implies some fluency in the patient's language. Certainly the perception of the students in this study was that the opportunity for patients to communicate in their first languages had a very positive effect not only on the quality of the information provided but also on the nature of the communication itself.

From the perspective of most students interviewed, there were significant differences in how they conducted medical interviews and clinical interactions depending on the language they used. When not using *their* first languages, they noted greater difficulty establishing rapport, less capacity to be culturally sensitive in phrasing questions and comments, an inability to use colloquial language to make the interaction more relaxed and less formal, and a tendency to use more closed questions to confine patient responses.

In relation to their use of Bahasa Malaysia in conducting medical interviews, many of the students, including several native speakers of Bahasa Malaysia, mentioned initial difficulty in accessing medical terminology and vocabulary. They attributed this to having learnt in English, practiced in English (e.g., during objective structured clinical examinations [OSCEs]) and being accustomed to thinking in English when engaged in medical communication. Some noted that there was sometimes no equivalent term in Bahasa Malaysia to the term they had learnt in English, and this sometimes made it difficult to provide clear explanations to the patient.

As noted above, another issue mentioned was patient expectations and assumptions about what language would be used in clinical interactions. This became an issue particularly where the medical student appeared to be of the same ethnicity as the patient but was not proficient in the patient's first language.

From a learning perspective, this study has implications in terms of how medical students are prepared for culturally and linguistically complex clinical learning environments. In the Malaysian context, some capacity to engage initially with patients in the national language (Bahasa Malaysia), or in the most widely spoken community languages (e.g., Tamil, Mandarin Chinese), seems desirable. As stated earlier, this is particularly important given that medical interpreters are rarely available in Malaysian hospitals. It is likely that *beginning* the communication process in the patient's first language where possible, even if needing to switch to another language at some point, could have a positive effect on many patient–clinician interactions. In fact, within the medical education program being researched in this study, this realisation has prompted attempts to develop a Bahasa Malaysia for Clinical Communication syllabus for students requiring this.

Preparing students for the *process* of negotiating and establishing the optimum language for interaction is important and needs to include acknowledging that the patient's language preferences may not always be able to be met. Providing strategies to best manage this will help students in what is undoubtedly a complex and challenging learning environment. Students choosing to avoid interactions with patients of particular ethnicities due to concerns about possible language and associated cultural issues could negatively impact on clinical learning, potentially lessening access to patients and limiting the breadth of clinical experiences. For this reason, acknowledging and exploring with students how cultural and language factors may impact on their clinical communication and clinical learning may need to be more explicitly addressed. Where such factors have the potential to impact on the quality of information elicited from patients and therefore on clinical safety, making the communication *process* more conscious rather than reactive may be of value.

Limitations

The perspective of the medical students who participated in this study is of considerable value in understanding their experiences of clinical learning and provides insights into the complex dynamics of how the language used for consultation influences clinical interactions. However, the perspectives of patients would clearly be of considerable interest and add a further dimension to our understanding. Lack of direct information on patient perceptions and attitudes is therefore a limitation of this study; further studies into *patient* perceptions of how the language of consultation influences clinical interactions, particularly in the Malaysian clinical context, presents a potentially valuable area for future research.

Although cultural and language diversity are increasingly a feature of many clinical environments globally, the Malaysian clinical environment is somewhat unique in terms of the particular dynamics of race, ethnicity and language. For this reason, some specific findings may not be transferable to other clinical settings, although in general terms we would argue that this study has broad relevance to clinical learning.

As noted briefly above, the politics around language use are complex in the Malaysian context. While this aspect is beyond the scope of this paper, it is appropriate to acknowledge that it may account for some patient attitudes and behaviours reported in the interviews as well as potentially influencing the perceptions of the students themselves in some cases.

Conclusion

This article explores the influence of language and culture on how medical interactions are conducted, particularly in one clinical learning setting in Malaysia but also for Malaysian-based medical students doing clinical rotations in Australia. From the perspective of the final-year medical student participants, it identifies ways in which the languages used by both the student doctors and their patients influence clinical learning and communication. It suggests that patient and practitioner language use both have the potential to influence not only the quality of the interaction from a clinical perspective

but also the capacity to establish rapport and create a comfortable and cooperative basis for communication. Language use can influence the type of questioning used, the amount and type of information elicited from patients, and the capacity to express ideas and information with sensitivity when required. The study highlighted some of the potential benefits of language congruence for clinical communication as well as some of the issues arising when language congruence between practitioner and patient is not present. In terms of clinical learning, a key finding is that where perceived shared ethnicity is not accompanied by language congruence, this can negatively influence interactions between medical student and patient, and even have an impact on *access* to patients for learning.

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