# Language usage in the field of health care

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Within the last 15 years, more than 2.5 million "migrants" attended special language courses [so-called integration courses] in Germany. In the last three years "vocational language courses" increased, especially courses in the field of health care. The aim of the article is to show that language analysis in accordance with Edda Weigand's MGM can help to get a better insight into language usage, needed especially in the field of health care. By means of analysing one specific medical dialogue, the need for seeing language use as intercultural use will be discussed.

**Keywords:** MGM, medical professionals, cross-linguistic influence, practice of dialogue, language learning



## 1. Introduction

Since 2005, Germany is a "country of immigration" and has implemented so called "language integration courses" on a large basis (cf. Statista 2022). Since 2005, almost 3 million people attended these "migrant" language courses (Statista 2015–2019: 2.329.916; 2020–2021: 200.000). Now, with many Ukrainians fleeing to Germany, these migration courses increase severely. We differentiate three groups of participants: migrants, refugees and so called qualified specialists, we try to get to work in Germany due to a shortage of specialists in some areas, like information technology, nursing and medical care. On July 1, 2016, next to these regular "migration language courses", so called "German for professional purposes courses / vocational courses" (*Berufssprachkurse*) were implemented and are considered as follow-up courses to the regular "language integration courses".

Now, what seems to be most difficult when learning German for professional purposes? Efing and Kiefer (2018) show that the basic problem of most learners is neither grammar nor vocabulary but the diverging practice of dialogue. Culturally shaped thought patterns and values of learner's native or first language, their "practice of dialogue" emerge when they learn a new language (cf. cross-linguistic influence (CLI), Alonso Alonso 2016; Grein 2020). Learners tend to "translate"

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(or transfer) their pragmatic concepts, their minimal action games (cf. Weigand 2017) into the new language, in this case German. Using the Mixed Game Model (MGM) as a tool for analysing authentic language games, I will show one example of language barriers due to these divergent concepts of dialogue setting. I will first outline the phenomenon of cross-linguistic transfer; then take a short glance at the MGM. Language teaching, especially in the field of "German for Medical Professionals", I conclude needs to be based on taking a closer look at authentic dialogues.



## 2. Language transfer or cross-linguistic transfer

The term "language transfer" is known since the 19th century, yet, moved into focus of research with the publication of Lado's monograph *Linguistics across cultures* (1957) (cf. Müller-Lancé 2006, 135). Odlin's (1989, 27) rather old definition of transfer is still in use: "the influence resulting from similarities and differences between target language and any other language that has been previously (and perhaps imperfectly) acquired". Thus, when learning a foreign language (L2), learners tend to transfer collocations, structures and speech act sequences (minimal and extended action games) from their L1 into the L2. If someone is learning a third language (L3), the transfer is based on either the L1 or the L2 or both (cf. Hufeisen and Marx 2007, 314, so-called factor model).

Within the field of multilingual didactics (*Mehrsprachigkeitsdidaktik*) Morkötter (2019, 321ff) specifies five areas of language transfer:

- form transfer (phonetics, morpho-syntax)
- lexical transfer (vocabulary, "false friends")
- functional transfer (transfer of linguistic regularities)
- pragmatic transfer (speech act sequences, i.e., minimal action games)
- didactic transfer (learning traditions)

Exhaustive research is done within the fields of form and lexical transfer. The Cross-Cultural Speech Act Realisation Programme (CCSARP, cf. Blum-Kulka and Olshtain (1984)) focusses on pragmatic transfer. They differentiate between direct, indirect and non con-conventional indirect expressions and overall strategies. Kusevska et al. (2016), for instance, apply the CCSARP approach to language teaching. With the help of a Discourse Completion Test (DCT), they aim at evaluating the pragmatic competence of learners. Speech acts, not minimal action games, are in the centre. Hudson et al. (1995) implemented several instruments for studying speech acts: written discourse completion task, multiple-choice discourse completion test, oral discourse completion task, discourse role-play task,

discourse self-assessment task, and role-play self-assessment. The tasks varied with respect to the power of the speaker, the social distance between speaker and listener, and the degree of imposition caused by the speech act. The results of these studies, for instance, reveal that "learners use too many indirect speech acts", "they are too formal", "they don't use sufficient politeness strategies" and so forth. In fact, the discourse role-play tasks are closest to the MGM approach by Edda Weigand (2010), applicable in foreign language teaching. Weigand (2009b, 120) claims:

> In learning a foreign language, students will become aware of the fact that there are, on the one hand, specific types of utterances, which, as types, seem to be universal: the direct, indirect and idiomatic utterance. On the other hand, they have to learn language-specific features, i.e. differences between their mother language and the foreign language.

Telling students that they are supposed to be more direct or less polite is not sufficient. The strategies are of great help for learners, but they fail to focus on different mostly culturally based concepts. I, thus, suggest an analysis in accordance to Weigand's MGM: teachers and learners have to take the practice of dialogue into account (cf. Grein 2020).

## 3. The minimal action game (Mixed Game Model – MGM)

According to the MGM, language-in-use can only be described within the framework of a holistic model, integrating the multiple human abilities such as cognition, perception, personal preferences, emotions, rational behaviour and cultural factors. In the dialogic view, the speaker is not facing the world (as in speech act theory), but another speaker within the world. Weigand (2010, 4) claims that the central linguistic interest is directed at describing and explaining how human beings, as cultural beings, succeed in coming to an understanding in human affairs. "Every human being brings their own cognitive horizons, preferences and emotions" (Weigand 2009a, 147). The language learner "knows" the communicative situation, but the "cultural script" might be completely different. Now, if a human being starts learning a new language, the choice of utterances is dependent on the communicative situation. Yet, the communicative situation might be interpreted completely different. The cognitive horizon, then, is divergent. This includes verbal and nonverbal factors (Is physical contact ok? Is visual contact ok? How long? How often?). Merse (2020, 63) illustrates differences within nonverbal behaviour. Nodding your head up and down is understood as agreement in North and Middle Europe, whereas the same movement means "no" in Syria, Bulgaria

and Greece. Turning your head from left to right (shaking your head) means "no" in North and Middle Europe whereas it implies agreement in Syria, Bulgaria and Greece. Especially within the field of medical care, a misinterpretation can cause severe misunderstandings. In Grein (2007), the MGM (minimal action game) was visualised:

Source: Pixabay

| **Speaker 1** | **Speaker 2** |
|---|---|
| individual imprint | individual imprint |
| cultural imprint | cultural imprint |
| specific cognition | specific cognition |
| emotions | emotions |
| principles of language usage (mostly based on L1) | principles of language usage (mostly based on L1) |
| dialogic claim | reaction to the claim |
| verbal, nonverbal, paraverbal | verbal, nonverbal, paraverbal |

**Figure 1.** The minimal action game

The cultural imprint and the specific cognition, especially in the field of medical treatment, can be diverse. I will address some basic differences in the next subsection.

## 4. Practice of dialogue in the field of medical treatment

Gonzales et al. (2018, 194) speak about the "rhetoric of health and medicine", focusing on issues of linguistic and cultural difference, a field subjected to numerous studies in the last decade.

> Scholars have presented frameworks such as "patient experience design (PXD)" (Meloncon 2017), "international patient experience design (I-PXD)" (St. Amant 2017), and "community-based user-experience design" (Rose et al., 2017) to help practitioners facilitate multilingual and cross-cultural healthcare interactions.
>
> (Gonzales et al. 2018, 194)

Health-related interactions depend on culturally shaped concepts of health, illness and the medical system. We have to consider different healthcare concepts when teaching a language. Cross (2020) explores the diverse perspectives of health, including the patient's own concept of health. In the Western world, we often refer to the definition of health from the World Health Organization (WHO). This suggests that health is "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (WHO 2006). This definition is positive in nature. Health can, however, be viewed either positively or negatively. McCartney et al. (2019) list nine different approaches to defining health, which are Western based. Yet, non-Western understandings need to be considered, too. Cross (2020, 4) for example lists four dimensions of health for the Maori:

1. *Hinengaro* (mental health, recognising the inseparability of mind and body)
2. *Wairua* (spiritual health, unseen and unspoken energies)
3. *Whānau* (health of the extended family)
4. *Tinana* (physical health)

The cause or trigger for the diseases vary; and depending on the cause, different treatments are suitable. For *Hinengaro*, one might need a "balance medical treatment"; *wairua* might need a punitive medical treatment and *tinana* a biomedical treatment.

What are the basic concepts of these three different understandings of causation of diseases (cf. Golsabahi-Broclawski, Broclawski, and Drekovic 2020, 135–145)?

Depending on the concept of medicine, on the one hand, and differences in power distance, on the other hand, the doctor-patient relationship differs. Emanuel and Emanuel (1992) argue that the main difference is the degree of the patient's participation within the decision making process. Four "concepts" are distinguished: (a) paternalistic: the "authority" (doctor) decides and "acts", (b) deliberative: the doctor informs what he/she is going to do, (c) informative: the doctor provides facts and makes suggestions; (d) interpretative: the doctor provides facts and helps the patients to find their preferences. Today, concepts (c) and (d) are often summarized as "shared-decision-making concept" (cf. Schildmann et al. 2018).

All treatments start with the anamnesis, understood as a guided history interview or medical history taking. According to Seitz et al. (2019), the competency in medical history taking is crucial. Oyedokun et al. (2016) point out the importance of the anamnesis and show differences for instance in African countries.

| Concepts | Causation of disease | Treatment | Countries |
|---|---|---|---|
| Punitive medicine | Punitive theory has its origin with the belief that diseases are a punishment by a deity for personal sins. Patients often hesitate to visit a regular medical doctor. | exorcism; punishment | still to be found in some regions in Saudi-Arabia, Pakistan, various Muslim countries, parts of Africa and so forth |
| Balance medicine | The balance between health and disease is a key concept. Diseases are a threat; physical integrity is of major importance. Diseases are a "defective". | treatment seeks to restore this balance through treatment specific to the individual; balance between the internal body organs and the external elements (acupuncture, herbs) | especially in China, India, Egypt, Syria, but getting more popular in Western countries |
| Biomedicine | The biomedical or medical model of health is a scientific measure of health and regards disease as the human body having a breakdown due to a biological reason. A patient is seen as a body that is sick and can be handled, explored and treated independently from their mind and other external considerations.* | concerned with the application of the principles of biology and biochemistry to medical research or practice | all countries |

* UK Essays. (November 2018). The Biomedical Model of Health. Retrieved from https://www.ukessays.com/essays/sociology/the-biomedical-model-of-health.php?vref=1 on 12.04.2022

We will take a short glance at one of these conversations between a German doctor and a Bosnian female patient and use the MGM to analyse this dialogue (cf. Golsabahi-Broclawski, Broclawski, and Drekovic 2020, 137).

**Doctor:** Hello, Mrs. … May I introduce myself. My name is …, I am the doctor on duty. What can I do for you?

**Patient:** Oh, honourable Doctor, I have a terrible stomach pain, I can hardly stand it.

**Doctor:** When did these physical problems start?

**Patient:** Well, I guess the Djinn is causing the problems. You know, I was not behaving properly when I was younger. I had a few boyfriends till I married. I didn't live according to our rules. Now I am married, but still …

**Doctor:** Well, and what is the Djinn, sorry, I don't understand.

**Patient:** Oh, he is coming at night and wants me to do penance. He causes difficulties in breathing and causes my stomach ache. He is gripping my stomach and crushes me.

**Doctor:** Oh ok, how often do you have these pains?

**Patient:** Hm, I pray a lot … but it does not really help, almost every night.

The patient has a good command of German: There are neither grammar, nor vocabulary problems. Her addressing the doctor as "honourable doctor" is a first indication of a different cultural imprint. Of greater importance, here, are her deviating thought patterns, which are culturally shaped: her concept of a disease is different. Whereas the German doctor conducts his standard anamnesis interview based on a biomedical approach and his belief in a shared-decision-making concept, the Bosnian female patient, 35 years of age, living in Germany has a punitive or balance concept, believing mind and body are inseparable entities and she is expecting an authority concept treatment. Her Muslim-based belief is that sex outside marriage is a punishment of Allah.

In short:

| **German doctor** | **Bosnian patient, 35 years** |
|---|---|
| biomedical approach standard anamnesis shared-decision-making concept | punitive concept, balance concept, mind and body inseparable, awaiting authority-concept |
| diagnosis: hypothyroidism and iron deficiency | her belief (Muslim-based): sex outside marriage can cause AIDS (even safer sex) or later punishment; lying and misbehaviour will cause different infections. |
| cognition: existence of diverse medical concepts is known | cognition: our medical beliefs are universal |
| emotion: empathy | emotion: fear |

Analysing authentic language games is indispensable. Especially, when medical personal is intending to work in Germany and originally has divergent concepts (i.e. punitive and paternalistic), they have to become aware of their own cultural imprint and their diverging cognitions. Future medical practitioners in Germany – which we need desperately – need to know that the physician is supposed to listen carefully and show empathy with the patient, they should be aware of diverging concepts of causes of diseases and they are supposed to apply the "shared-decision-making concept". Of course, grammar and vocabulary are essential, but the key to being a successful medical practitioner is the knowledge of underlying concepts.

## 5. A brief synopsis

The article presented diverging concepts within the field of medical treatment and healthcare. Culturally shaped concepts are transferred from the first language (culture) to the new language. Concepts in the field of medical treatment are extremely divers. An analysis of authentic examples, taking the individuality of speakers, their culturally shaped beliefs, cognition, emotions and principles of language usage into account, is necessary to disclose the differences. Cultural sensitivity is a key task in the business world and especially within medical treatment (cf. Henderson et al. 2018). Henderson et al. (2018, 591) claim "Increasing clarity can assist healthcare providers to better understand this evolving concept and provide care that is culturally appropriate and competent, improving quality, the effectiveness of healthcare provision and reducing health disparities". Only when different concepts are revealed, they can be integrated into German language classes and textbooks. Edda Weigand's approach, which does not analyse single speech acts but rather speech act sequences, with cultural background being a fundamental factor, should be used much more extensively in the analysis of conversations in the field of medicine. Ultimately, this would help integrate the results into the foreign language domain.



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