English as a Lingua Franca in Public Health Care Services

The Spanish Challenge

Sonia Oliver

Autonomous University of Barcelona

Abstract

Throughout the last few decades, English has become the *lingua franca* for professionals in many fields. However, within the framework of health services in Spain, English does not seem to work as the main vehicle of communication among providers and users. Therefore, the goal of this study is to shed light into how and why certain categorization of languages frequently emerge and circulate in public health institutions. In this sense, our method is based on ethnographic fieldwork and includes 10 interviews with key members of one Health Care Unit for women. Our results seem to corroborate that medical discourses work at institutional, professional, and moral levels and that the way the Institution supports or prioritizes English, in particular, unfolds certain linguistic hierarchies underlying governmental policies as it is made more accessible and considered "better" by medical professionals and staff.

Keywords: *English, lingua franca, language proficiency, health, migration*

Introduction

Over the last two decades there has been a substantial increase of migration flows in Spain. This mobility of citizens from other countries and other cultures has set an important challenge for a modern society which faces, for the first time, a much greater demand for social services, among others, health care. Previous studies show that immigration in Catalonia totals 11, 4%[1] of the population while Spain has 8,5% of migrant population and from year 2001 figures have increased considerably. Maternity and paediatrics seem to be the services most used by newcomers. Therefore, in this paper, we focus on the scope and nature of multilingual practices in an institutional space especially created for women (PASSIR) Programa d'Atenció a la Salut Sexual i Reproductiva de la Dona. In this sense, we view language and other social practices as interdependent (Ciccourel, 1992) and, therefore, our ethnographic fieldwork aims at unveiling the way language and migration discourses are constructed and how these two key concepts might intersect. Observations of medical practice show that medical discourses work at institutional, professional, and moral levels generating complex layers of contexts (Måseide, 2007). Thereby, our concern is to shed light into how and why certain categorization of languages frequently emerge and circulate in public health institutions. In this sense, the present research aims to investigate linguistic practices in a public health care clinic which offers services to immigrant women and, therefore, a very suitable place to study how intercultural communication works in terms of agency and negotiating transnational spaces in multilingual encounters (Moyer, 2010).

One of the main concerns of this study are the kinds of language being used and, particularly, in relation to language choice by the social actors involved in the interaction, namely, doctors, nurses and users. Besides, we assess the importance of how these practices are related to different ways of thinking about language and linguistic diversity and, in particular, the role migrant users play in these interactions. In addition, we focus on the range of strategies used to negotiate meaning and linguistic variation and the possible role of English in a globalized world and its potential function as a lingua franca in multilingual encounters.

Through our ethnographic study carried out during 2008-2009 in this health care clinic for women in an industrial city, located in the outskirts of Barcelona, we were able to observe how language practices and processes of social categorization may run parallel in the health context and, more precisely, the analysis of our data seems to show that medical professionals consider certain languages "better" or make it more accessible than others but these logics point out how medical and public health discourses, framed as bounded, specialized and scientific, incorporate a heterogeneous range of discourse, including popular stereotypes (Briggs, 2005).

The way public institutions deal with ethnicity and control citizen bodies is another issue of our concern in this study since besides from observing and understanding how health practices are carried out in the public sector we are also aiming at perceiving how migrant users experience health care in Spain and, particularly, in a Catalan health center (space) especially created to meet women's needs. And our interest lies in finding out how this clinic fits into such practices. From a much broader scope, it is relevant the way economic, political, and ideological factors are associated to this recent phenomenon of globalization and the remarkable role public institutional spaces play in social interactions with migrant population. And it is undeniable that the right to language access is fundamental to migrant's empowerment and equality.

Context

Steger (2003:9) summarizes four distinct qualities or characteristics of the globalization phenomenon:

> *First, globalization involves the creation of new and the multiplication of existing social networks and activities that increasingly overcome traditional political, economic, cultural and geographical boundaries. (…) The second quality of globalization is reflected in the expansion and stretching of social relations, activities, and interdependencies. (…)Third, globalization involves the intensification and acceleration of social exchanges and activities. Fourth, (…) globalization processes also involve the subjective plane of human consciousness (…) which gradually change people's individual and collective identities.*

As we have already mentioned, new global processes have allowed a greater mobility and exchange of people and information across borders. This mobility has brought about a new multilingualism in Catalan society which did not exist in the recent past. In the context of globalization, Primary Attention Centres or Centre d'Atenció Primària (CAP) in Catalonia with staff and users from many different linguistic and cultural backgrounds, embody the challenge to build cross-cultural and multilingual spaces in our society and, hence, play a key role in the sociolinguistic studies of multilinguals in their communities.

In this sense, the profile of mobile citizens searching for a better life in Spain seems to have changed throughout the last few years as their life-trajectories are rather diverse depending on the continent they originally come from. Statistics show that immigrants from Magreb and Subsaharian Africa are mainly young single men in search for a job to support their family back home. However, comers from South America are basically couples who usually leave children behind until they are settled down and can get reunited. In our study, mainly focused on the scope and nature of multilingual practices in an institutional space, female users are provided with information and assistance on sexuality, family planning, youngsters education, motherhood, fertility matters, contraceptive methods, pathologies, health education for specific collectives and risk groups.

On the other hand, the ability to communicate in several languages is obviously a great benefit for individuals, organisations and companies alike as it enhances creativity, breaks cultural stereotypes and encourages thinking (Orban, 2008). But the fact is that although English is spoken by an estimated 38% of EU citizens as their first foreign language and 14% EU citizens have either French of German as their first foreign language in seven EU countries (Hungary, Ireland, Italy, Portugal, Romania, Spain and the United Kingdom) between one half and two thirds of the population do not know any foreign language.

One possible reason for tensions around the role of English may be the lack of proficiency in foreign languages of the staff working in health care, as is the case of administrative workers, nurses and even practitioners to the surprise of its non-western English users. Following Baraldi's (2009) idea of conflict as the trigger for changes in the social system we can see how the Institution is constantly trying to find ways to cope with users' needs in terms of language access.

Another aspect to be considered when focusing on multilingual interaction at a health centre is how culture is interpreted by staff, doctors and users. Perceptions on ideologies that neglect cultural traits when dealing with doctor-patient linguistic barriers make communication even more difficult in some cases. The way medicine is practised may vary a great deal depending on the background origin of the user and having trouble expressing oneself or making oneself understood properly can generate tension and health care providers, at the moment, do not have adequate linguistic or cultural resources to meet the needs of most migrant users.

As a matter of fact, one direct way of assessing cultural changes due to the globalization processes is observing the shifting patterns of language use (Steger, 2003). While some languages increase their presence others lose their prominence or even disappear as we might observe in nowadays intercultural practices.

According to the Social Consensus of Immigration in Catalonia the current health system clearly lacks resources and the arrival of immigrant population just made it more visible. There has been a significant change in the social, cultural and demographical profile and the system could not foresee in their previous planning factors, such as the lack of health and social resources when the demand of services increased. As a matter of fact, the Pla Director d'Inmigració from the Catalan government considers the latter when strategically developing a set of measures based on a) Pla d'Acollida (*welcome plan*), b) Pla de Mediació (*mediating plan*) and c) pla de Formació (*training plan*) once they finally detected serious weaknesses in the kind of service provided to migrant population in the health sector. Therefore, actions beyond language barriers have been planned and the recognition of the key role of mediators has been stated. In fact, multiple and very diverse situations can be faced by health professionals when dealing with this sector of the population. Governmental policies pursue an inclusion of migrant users and try to display a set of measures to integrate mobile citizens linguistically, culturally, socially and politically as experts are aware of the specific needs these inhabitants have in terms of health issues, that is to say, a closer interaction and efficient mediation especially in cases of mental health problems or sexual and reproductive matters.

In this study we conceive multilingualism as both social practice and ideology and we focus on the institutional assumptions of literacy and competence in standard varieties to participate in healthcare procedures. Prior works on the field (Erickson, 2001, Baraldi 2009, Urry & Sheller 2006 and Verschueren 2008) provide us a framework to observe intercultural encounters in a health care unit where there is noticeable transnational migration to the bilingual (Spanish and Catalan) community of Catalonia as Spain is giving rise to new forms of communication. In this sense, multilingual practices are defined by institutional ideologies about: a) ideologies, b) meaning-making processes and c) patients' health care needs.

We must highlight here the two major studies on doctor-patient interaction. The first one, carried out by Korsch & Negrete (1972) in which observations of 800 paediatric acute care visits were performed and the second one, by Byrne & Long (1976) which based their *Doctors talking to Patients* on 2500 audio recordings of primary care encounters. These experts developed a taxonomy proposal of doctors' behaviour following the steps observed within the interactions. The former study showed existing problems in doctor- patient communication, the latter was an outstanding work but mainly focused on the professionals' side. However, more recently Heritage & Maynard's study (2006) shed some light into the evolution of current practice moving from a more doctor-centred approach toward a more "blended" view of all the actors in those medical encounters, namely, doctors and patients and that is the framework that we adopt in the fieldwork that we report in this paper. Therefore, the data gathered in the present study can contribute to improve the knowledge about a new sociolinguistic situation in Spain and will help better understand the role of language in the new economy of public services.

Objectives and research questions

The present investigation is part of the research project: *The Management of Multilingualism Management in three Institutional Sites* (REF.HUM2007/61864/FILO) which aims at investigating linguistic practices in 3 institutions which offer their services to immigrant communities: a) non-governmental organization, b) a multinational company based in Spain and c) a public health care centre, which is the focus of the present study. Our initial hypothesis holds that changes resulting from an increasingly globalized economy have contributed to a new situation of multilingualism in the Spanish and Catalan context. Therefore, the object of the present investigation is to report an ethnographic study at a health centre for women:

a. To observe the multilingual practices (the distribution of languages) in the institution,
b. To analyse and characterize multilingual interactions and the strategies adopted to negotiate meaning as well as language diversity and
c. To study the role of English in a global world and in particular how it works as a lingua franca.

And our general research questions are the following:

1. What kind of (oral/written/computer mediated) linguistic practices take place in our site?
2. What language ideologies are behind those practices?
3. What discourses about languages are produced? By whom? In which situations?
4. How does the use of a particular language/ produce a hierarchical difference?
5. Since the challenge of linguistic and/or cultural interaction is recognized but scarcely tackled… What social positions are taken under pressure? Who decides what and where in the Institution?

Methods

After choosing our site based on the services provided (both applying for and obtaining the national health card and delivering medical care) and the amount of immigrant population having access to it we had several meetings with the responsible staff to have access to the site. Afterwards, we officially presented our research project and carried out fieldwork (which included observations and 10h audiorecording of medical encounters from 2008-2009). In this period of time information about the organization and management of the centre was collected, especially, the services related to the attention/care of women and children: brochures, websites, information sheets, management documents, and official laws. Secondly, fieldnotes were taken: a) both inside and outside the surgery, b) at the reception desk and d) while being allowed to attend 4 staff's meetings (including training sessions). In addition, 4 formal and 6 semi-formal interviews with key members of the Institution were carried out during all the observation period. All the subjects recorded were informed of the purpose of the observation/recording beforehand and they signed an informed consent following our Institutional Ethical Committee procedures. As to the profile of the subjects (N=10) they were aged between 30 and 60, 3 male and 7 female. And according to their work category within the Institution: Director (N=1), Head of Unit (N=1), Administrative workers (N=3), Nurses (N=2) and Practitioners (N=3).

Results

In this section we describe the qualitative outcome of our observations on 1) the kind of linguistic practices taking place in the site, 2) the language ideologies behind those practices, 3) the discourses circulating on languages, 4) the possible hierarchization of the languages used in the medical encounters and 5) health professionals' cultural awareness in their daily practice.

1) Spanish practitioners have a restriction of time per visit, which is much higher than the average in the European Union (6 minutes versus 15), they sometimes relay on tools which, even provided by the local government (Generalitat de Catalunya) do not facilitate interaction with migrant users (i.e. automatic translator EPOCA) or online interpreting (available only some of the times). The former giving a translation, such as *"good day, how it is said?* when the user's input in her mother tongue (Catalan) was: *bon dia, com és diu?* /¡Buenos dias! ¿Como se llama? (in Spanish) which would be, then, *Good morning, what is your name?*

Or even obtaining an even more literal translation when asking in Catalan: *bon dia, que vol?* / ¡Buenos dias! ¿Qué desea? in Spanish and seeing on their computer screen: *good day, which wants?* A question that makes no sense at all in English as the correct way to ask the question would be: *Good morning, how can I help you?*

The available multilingual texts, on the other hand, show that specific brochures (i.e. cancer) are only offered in the local official languages (Spanish and Catalan) whereas others on domestic violence are translated into English, Arabic or Chinese. Doctors have multilingual dictionaries available and translated material provided by pharmaceutical companies which they hardly ever use. In addition, they are not very familiar with the specific software available in their intranet (Universal Doctor) which offers written and oral explanations related to the medical field in many languages including English, French, Chinese and Russian. The following quotation from a professional in the primary health care confirms the perception of having useless resources provided at present:

> *I do not think that a dictionary like that (a multilingual one) is a suitable tool…this does not help me at all…it is a real waste of time (Doctor1)*

2) According to the ideology manifested through Institutional actors so as to provide efficient services to migrant population staff at health centres should be able to speak foreign languages to immigrants and be aware of cultural diversity but when asking on foreign language skills most staff claims to have little or no level of English. What is more, senior professionals seem to be proficient only in French. Thus, migrant users who do not speak Catalan or Spanish usually bring a sibling when the site does not facilitate nation-state languages' acquisition or a mediator to be able to communicate as illustrated in the excerpt below:

> *Sometimes, I have the cases of women from Magreb who do not speak or understand anything and, sometimes, children who attend school here (in Catalonia) aged seven or eight carry out the task of translating for them (Doctor2)*

3) As to discourses on languages: a possible reason for the absence of English in medical/office workers encounters with patients would be the constantly changing profile of migrant citizens who mainly use Chinese, French or Arabic languages in their day-to-day interactions at the health centre. Nevertheless, English holds a reputation of prestige and it is still the most widely used language among users from the European Union. In addition, English is permanently present in high peer communication when transferring knowledge, presenting advances in science, attending conferences or working in multinational settings, in other words, present in the professional practice. In fact, the institution clearly prioritizes its use by making it the first language to be present in every single material translated (for the use of both health providers and users) and it seems ideologically conceived as the first foreign language to be used when problems of communication arise but the main reasons for learning English are for going on holiday or work-related.

4) In this sense, according to the data gathered during our ethnographic fieldwork there are certain organizational and interactional processes which lead to a hierarchy of some particular languages over others and that is the case of Catalan over Spanish and English being prioritized over French, Punjabi, Urdú or Arabic, which are the languages mostly used by the migrant population in our site. As a matter of fact, Undocumented migrants quite often avoid the access to health services so as not to unfold their "fragile" situation and those who are illiterate or lack language skills find themselves overwhelmed with bureaucracy and do not seem to understand the administrative procedures of this country properly. Rather

often, professionals do not know whether the migrant user understood the explanations provided on medical doses, illness prevention or follow-up visits or the user left without knowing what to do next.

But it would appear that too much reliance is placed on self-sufficiency in English as the international lingua franca, when even English speaking countries say that "English is not enough" (Elan Report, 2006) meaning that there are issues in intercultural communication that go beyond the linguistic differences or apparent barriers, in other, words, cultural aspects.

5) Culture and cultural diversity is seen by practitioners as more workload, scarce tools and often lack of institutional support. What is more, this circulation of people and money flow from the "new economy" challenges the previous state budget suffering from severe restrictions due to the present world economic crisis. In the site, important decisions are being taken by doctors, for example, whether a user is eligible for certain surgery or treatment. There is certain priority in cases and the amount of prescriptions, operations, tests and follow-up visits are decided by practitioners although they are supposed to follow a "strict" protocol and are controlled by Institutional budgets. As stated by Sarangi and Roberts (1999:64):

> *Within the institutional order of medicine and other disciplines we are becoming increasingly aware of a model of cost-centre management which regulates not only the quality of patient care, but also the division and affordability of interprofessional expertise.*

As we have previously mentioned, some professionals in our site do not have foreign language proficiency nor share any common language with the migrant user in some of the encounters taking place. Thus, these practitioners might depend on mediators, other staff or the own user's relatives or neighbours to guarantee a fluent interaction. Scarcely used it is the Catalan phone-line Sanitat Respon (*Healh Care Answers*) which according to some doctor users is rather limited:

> *A medical interview is not just verbal communication; there are things that cannot be transmitted in the same way; they translate what they understand, and it is not direct communication and in this process much information is lost, which is exactly the one we would not like to lose (Doctor 3)*

And nurses also face challenges in terms of immigrant cultural traditions. The following fragment describes an episode which occurred at the Hospital which co-works with our site in maternity matters. In this sense, the excerpt highlights how nurses were very worried about Subsaharian mothers' reactions after giving birth and seeing their newborn babies for the first time:

> *You do not have any previous idea and that is why you need some previous knowledge about it. Mothers do not look at their just newborns since they want to protect them. For us it was a sign of neglecting their own child but when you know why mothers do it you can understand the situation and you help by being there and protecting the baby at that particular moment. We must know things and therefore, we need training. (Head of Social Services)*

Conclusions

According to the *Pla Director d'Inmigració en l'Àmbit de la Salut* only 4.3% of the budget in health matters in Catalonia is devoted to migrant policies when the percentage of migrant population is approximately of 12.6%. There are several reasons that justify such a political decision. First, migrant users in Catalonia are younger than local users. Therefore, the former demand less health care services than the latter. Second, official surveys show that migrants seem to be healthier when compared with citizens of the same age range as only the ones who have good physical conditions to migrate seem to do so. Finally, and as mentioned in the previous section of this paper, some migrant users have more difficulties to gain access to public health services because of language barriers and/ or cultural differences.

In general, the public health system in Spain seem to lack professional training to meet the requirements of the steady migrant flow and often according to the *Consens social sobre migracions a Catalunya* (2006) it requires a "greater social and anthropological awareness and sensitivity". It is well known that migrant users experience very diverse realities based on their country of origin and often according to the social class they belong to, their particular life trajectories, their educational background and their personal resources, among other variables.

Therefore, the incorporation of mediators in the institution seems very positive but it is still seen as a temporary resource. In addition, the percentage of professionals in this field is very low compared to the high demand of their services, especially, the one coming from health care providers who really need these professionals help to provide an efficient service to their users. It is a fact that mediation resources are less in primary care services than in hospital care and that most "challenging" areas are those with a higher percentage of migrant users from countries outside the European Union who do not speak Spanish (mostly from Morocco, Romania and China).

In addition, health practitioners in Catalonia perceive, in general, that their visiting time restriction is a crucial challenge as it makes health care providers work under pressure, without many resources available and with a rather higher number of users than before. And, for them, quality time is especially important for the users who need specific requirements because of their particular circumstances or their lack of linguistic and/or communication skills.

One possible reason for the absence of English speaking in the ordinary medical practice would be the constantly changing profile of migrant citizens who mainly use Chinese, French or Arabic languages in their day-to-day interactions at the primary care health centre. Nevertheless, English is still the most widely used language among users from the European Union and it is permanently present in high medical peer communication when transferring knowledge, presenting advances in science, attending conferences or working in multinational settings as mentioned before.

Nevertheless, according to a survey on health conducted in the area of Barcelona in 2008 the perception of health professionals on the migratory phenomenon and healthcare services show that although most of them think that there are no barriers in access to services nor in obtaining the TSI (health card), reports from administrators and cultural mediators qualify, at least, this perception. The main attention difficulty manifested by health care professionals refers to interaction with the user if the latter speaks no Catalan or Spanish.

We could say that cultural distance is also made evident in discourses by the institution, practitioners and the administrative staff in the public health sector. In addition, this is viewed with great concern by local and national governments and they see the need for intercultural training addressed to healthcare professionals. However, it is non-manual class men, and men and women alike born in other countries who have the highest opinion in the evaluation of public health services in Catalonia. In this sense, we follow Verschueren concept of adaptability (2008: 24):

> *Communication is indeed never absolute. In order to explain the fact that language can still achieve its communicative purpose with a significant degree of success in spite of the use of variable means that cannot be interpreted mechanically, we rely on the concept of adaptability. Communicative means and their use can be continually returned or adapted. That is why an intercultural context is not to be equated with the sum of two different contexts, but essentially the creation of a new one.*

Finally, we might state that turning language diversity into a competitive advantage will only be possible if governments encourage language learning at all levels and widen the range of languages taught, with a practical and professional orientation and including programmes for lifelong learning and social integration as suggested by Elan survey from the European Commission (2006).

We would like to conclude our paper with the following quotation by Blommaert et al (2005:198) as a reflection of the need to carry out further research in our site, where a triangulation of patients'

perceptions of health encounters, doctors' observations and office workers' experiences on a daily basis could be crucial to understand how this particular space (a Health Care Clinic for Women in Spain) overcomes intercultural challenges:

> *Individuals maintain (and may even expand) their repertoires and skills, but the function and value of these resources and skills in that particular environment have changed. Stated in the clearest possible terms: communication problems in such situations are the result of how individuals and their communicative "baggage" are inserted into regimes of language valid in that particular space. Consequently, space in itself demands closer investigation if we intend to analyze the way in which multilingualism operates in and across societies nowadays.*

References

Baraldi, C. (2009) Forms of mediation: the case of interpreter-mediated interactions in medical systems. *Language and Intercultural Communication*. Vol.9, No2, 120-137.

Blommaert, J.; Collins, J.; & Slembrouck, S. (2005) Spaces of multilingualism. Language & Communication 25, 197-216.

Briggs, C.L. (2005) Communicability, Racial Discourse, and Disease. *Annual Review of Anthropology* Vol.34, 269-91.

Byrne P. & Long B. (1976) Doctors Talking to Patients: A Study of the Verbal Behaviours of Doctors in the Consultation. London: HMSO.

Ciccourel, A.V. (1992) The interpenetration of communicative contexts: examples from medical encounters. In A. Duranti & C. Goodwin. Rethinking context: Language as an interactive phenomenon. *Studies in the social and cultural foundations of language* 11. Cambridge University Press.183-224.

Heritage, J. & Maynard, D. (2006) Problems and Prospects in the Study of Physician-Patient Interaction. 30 Years of Research. *Annual Review of Sociology* 32:351–74

Korsch M. & Negrete V. (1972) Doctor-patient communication. *Science American* 227:66–74.

Måseide, P. (2007) Discourses of collaborative medical work. *Text & Talk* Vol.27, No.5/6, 611-632.

Moyer, M. (2010). The management of multilingualism in public, private and non-governmental institutions. Sociolinguistic Studies 4.2: 267-296.

Moyer, M. (2010) What Multilingualism? Agency and Unintended Consequences of Multilingual Practices in a Barcelona Health Clinic. *Journal of Pragmatics* 43(5) 209-221.

Orban, L. (2008) Speaking for Europe. Languages in the European Union. Luxembourg: Office for Official Publications of the European Communities.

Sarangi, S. and Roberts, C. (1999) Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings. Berlin: Mouton de Gruyter, Berlin and New York.

Steger, M. (2003) Globalization. A Very Short Introduction. Oxford University Press.

Verschueren, J. (2008). Intercultural Communication and the Challenges of Migration. *Language and Intercultural Communication*, Vol.8, No.1 21-35.

Institutional Documents

Atenció a la salut dels inmigrants: necessitats sentides pel personal responsable. Generalitat de Catalunya. Departament de Salut (2007).

Informe Elan (Efectes en l'economia europea de la manca de coneixements de llengües estrangeres a l'empresa). Comissió Europea, 2006.

Informe Tècnic. Necessitats en salut i utilització dels serveis. Revisió exhaustiva de la literatura científica (2004). Agència de la tecnologia i recerca mèdiques. CatSalut. Departament de Sanitat i Seguretat Social. Generalitat de Catalunya.

La Població vulnerable a Barcelona. Consorci Sanitari de Barcelona. Corporació Sanitària de Barcelona. Agència de Salut Pública. (2006)

La salut de la población immigrant de Barcelona. Agència de Salut Pública de Barcelona. Juny 2008.

Pla Director d'Inmigració en l'Àmbit de la Salut. Planificació i Avaluació. Generalitat de Catalunya. Departament de Salut. (2006)

Polítiques sanitàries per a la población inmigrant en el context nacional i internacional. Consorci Hospitalari de Catalunya i Generalitat de Catalunya. Departament de Salut (2007).

Sabadell: Informe de la immigració 2006. Diagnosi participativa de la immigració a Sabadell. Lliga dels Drets dels Pobles i Fòrum IDEA (UAB). Consens Social sobre Migracions (2006)

Appendix

Pattern of questions for formal and semi-formal interviews included the following information:

1. What is your work experience in this Institution? How long have you been working in this site?
2. What are the main duties that you carry out on a daily basis?
3. How have you experienced the globalization phenomenon in your working place?
4. How good are you at foreign language speaking? Which language do you use the most and why?
5. Have you detected any language "barriers" with migrant patients when delivering service? How do you "solve" communication problems when they arise?
6. Have you observed diversity in the cultural approaches to medical practice?
7. How would you improve the service?

About the Author

Head of Unit at the Faculty of Education from the Department of English and German Philology in the Autonomous University of Barcelona. Degree in Anglo-German Philology (University of Barcelona, 1992). Phd in Translation and Interpreting (University Pompeu Fabra, 2004). Coordinator of Masters Modules (Practicum, Masters Thesis, Advanced Academic Abilities) and teaching ESP and EAP for the last 14 years. Dr Sonia Oliver does active research in digital literacies, intercultural communication, EAP&ESP, contrastive rhetoric and corpus linguistics

Author's Address

Dr Sonia Oliver del Olmo
Autonomous University of Barcelona

Department of English and German Philology
Building G6 Office 214
08193 Campus Bellaterra (Cerdanyola del Vallès)
Barcelona (Spain)

[1] Source: Pla Director d'Immigració en l'Àmbit de la Salut (2006). PD. Planificació i Avaluació. Generalitat de Catalunya. Departament de Salut. (Health Care Plan).