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English as a Lingua Franca: Its Use in the Field of Medicine

Relatrice
Prof.ssa Fiona Clare Dalziel

Laureanda
Martina Carraro
n° matr.1225566 / LTLLM

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INTRODUCTION

The aim of this dissertation is to observe the main characteristics of one of the best-known phenomena involving the English language, namely the use of ELF as a Lingua Franca and, in particular, how it has also expanded within science and medicine. The idea of observing the functioning and peculiarities of the ELF in the field of medicine stems from the union of two well-founded interests, namely that for the English language as a means of communication, by now, global, and the interest in everything related to medicine. Specifically, in the first chapter of this thesis, we will trace the history of the development of the English language and see how it managed to obtain the status of global language and Lingua Franca, as well as that of the most widespread and most widely used means of communication between ethnic groups that do not share any cultural, scientific, economic, or political background, taking the place of previous lingua franca's such as first Latin and then French. Moreover, globalisation and the development of communication technologies, including the advent of the Internet, created the need for the various communities around the world to communicate with each other, hence the use of English to bring together, linguistically speaking, both people who share the same mother tongue, but especially those who speak different languages. Precisely for this reason, the main aim of this type of communication is not to use correct vocabulary, grammar or pronunciation, but rather to adapt and find a linguistic common ground in order to have successful communication with interlocutors. Just as ELF dominates in many fields, it is also of such importance in the international medical community as English is the language par excellence for scientific and medical communication. In the second chapter, in fact, it will be observed that knowledge of English, even for those who do not have it as a first language, is necessary in oral as well as written interactions for anyone wishing to be considered in this field. MELF shares many characteristics with ELF, but at the same time differs from others, that is, MELF is more geared towards a process of standardisation and codification due to its highly risky nature that requires the study

or sharing of accurate information through equally careful and precise terminology and speech because, if this is not done, disastrous consequences may ensue. In addition, in medical settings and especially in contact with patients, MELF communication should be enriched with non-verbal forms of language such as physical demonstrations, gestures, eye contact, posture, all of which can reduce the possibility of misunderstandings or language barriers. For this reason, in the teaching of medicine and health care in ELF contexts, the focus is on imparting a broad knowledge of language skills, but, at the same time through less passive teaching approaches, also in techniques for a sociolinguistic and cultural awareness of others, for greater flexibility of language and greater openness and empathy towards the interlocutor. Finally, the third chapter of this thesis will feature the answers obtained from a survey previously submitted to the students of the course delivered in English "Medicine and Surgery" at the University of Padua, which, according to the opinions and knowledge of the respondents, will either confirm the theory previously expounded concerning the use of English as a Lingua Franca in the medical field, or prove the opposite.

CHAPTER ONE
ENGLISH AS A LINGUA FRANCA (ELF)

INTRODUCTION

This first chapter focuses on shedding light on the issue of English used as a Lingua Franca around the world, a language whose status is becoming increasingly important and popular. Its expansion through migration, colonisation and globalisation has transformed the English language into an international communication tool, so much so that event 20 years ago, it was already considered by Kachru and Nelson (2001:9) "the most widely taught, read and spoken language the world has ever known". Among the large number of English speakers, it will be seen how for some of them it is their native language, which is why they are referred to as native English speakers (NESs), for others, defined as non-native English speakers (NNESs), an acquired second language, and for others a foreign language studied and used in various fields such as international organisations, academia, science, business or politics.

Since English has often been used in environments that are geographically and culturally different and distant from those of the native English speakers (mainly NNESs-NNESs interactions), it can be inferred that English used as a Lingua Franca has lexicogrammar, phonological and pragmatic differences from standard English. Indeed, as Seidlhofer (Kuo 2006:4) points out "there are commonly used constructions, lexical items and sound patterns which are ungrammatical in Standard English but generally unproblematic in ELF communication".

1 THE SPREAD OF THE ENGLISH LANGUAGE IN HISTORY

The Age of Discoveries saw the beginning of the spread of English outside the British Isles. During the 15th to 18th centuries, European empires began to explore the world (Stevenson 2002:196), claiming new lands for their countries and discovering hidden treasures like gold or spices in future colonies. Colonial nations

included Spain, Portugal, France, Great Britain, and the Netherlands. When they declared their colonies and brought new settlers, not only were their culture, laws, institutions, politics implemented, but their languages as well (Stevenson 2002:197).

In addition, from the 20th century, the story of English has been closely linked to the rise of the United States as a superpower that has spread the language alongside its economic, technological, and cultural influence, because, as Crystal states, "It may take a military powerful nation to establish a language, but it takes an economically powerful one to maintain and expand it" (Crystal 2003:85). Although the British Empire started to decline after the World War I, the power of the United States and its rise in population enabled English to remain applicable and to reach the position it is currently holding. That is, English is the most widely spoken language in the world and the third most spoken mother tongue after Chinese and Spanish. According to Ethnologue 2022[1] (25th edition), in fact, there are an estimated 430 million speakers of English as a native language (ENL), while around 300 million speak it alongside their national or native language (English as a second language, ESL). About 200 million have learnt it at school (English as a foreign language, EFL), in countries where this language is not in use. The number of those who use English as a second or foreign language thus exceeds that of those who speak it from birth. Nowadays, these numbers have been reached because after the World War II, English became the lingua franca par excellence, overthrowing the previous supremacy of French, which in turn had replaced Latin for diplomatic and scientific communication purposes. English has become the most studied language in the world, as well as the most important in the economic sphere, a tool for communication between ethnic groups with no cultural, scientific, or political connections.

One might think that the future of the English language and its role as a Lingua Franca and Global Language had already been predicted: the first time was in 1780, on the occasion of the proposal to Congress for an American Academy when the second president of the United States John Adams wrote (in Crystal 1998:66) "English is destined to be in the next and succeeding centuries more

[1] https://www.ethnologue.com/guides/most-spoken-languages

generally the language of the world than Latin was in the past or French is in the present age […]. Then, a famous German philologist, Jacob Grimm highlighted "English may be called justly a language of the world, destined to reign in the future with still more extensive sway over all parts of the globe" (Crystal 1998:66).

1.1 THE EXPANSION OF ENGLISH FROM THE 20TH CENTURY ONWARDS

In the past, several languages held the title of Lingua Franca in distinct areas of the world. However, English has surpassed all of them achieving a dominant role. English has entered most spheres of society, it has not only spread among its speakers and due to its worldwide impact, it can be defined "the world's Lingua Franca" (Björkman 2013:3). There are two main reasons why English has gained global prominence. Firstly, the British Empire, thanks to its geopolitical dominance, contributed to spreading English through its colonies. As a result of this phenomenon, the English language became either the first or second language in many countries that are not British territories anymore. This presence in the world was kept almost entirely thanks to the economic supremacy of the emerging American superpower (Crystal 2003:10), which began a process of Americanisation that undoubtedly influenced linguistic attitudes by homogenising globalisation and internationalising its economy. All this took place thanks to American funds made available through the Marshall Plan to implement the 'European Recovery Programme' (Keresztes 2009: 56). Indeed, since 1945, the United States had become the most important economic and cultural power; the economy had replaced politics as the main driving force, and the language of the American dollar was English.

Linguistically, one of the main consequences of this process of colonisation and globalisation was the emergence of Creole and Pidgin languages in response to the then communities' need to communicate and trade with each other, as these languages combined elements of their different languages (Crystal 2003:11). Furthermore, in the mid-20th century there arose the need for a common language with the founding of international organizations such as the United Nations, the World Bank, UNESCO, UNICEF, and the World Health Organization, but also, on

a more restricted level, the Commonwealth and the European Union, where an official language were requested in order to minimise the translation costs (Crystal 2003:12). Afterwards the dramatic expansion of communication technologies such as telegraphs and later in the 1990s through the internet paved the way for the English language to become worldwide. For the first time in history, a language has reached truly global dimensions, across continents, domains, and social strata (Seidlhofer 2004:211). Secondly, in addition to the practical needs of international organisations to have a common language, as mentioned above, communities of people from all over the world were also increasingly beginning to feel the need to communicate with each other, be it for academic (courses and conferences) or commercial reasons, scientific publications, or audio-visual cultural product (e.g., film, popular music) but also for individual reasons (Crystal 2003:13). Certainly, globalisation and the consequent development of air transport and modern communication technologies allowed this phenomenon, that is, the adoption of a single Lingua Franca, to be increasingly effective and visible in the world.

> There are no precedents in human history for what happens to languages, in such circumstances of rapid change. There has never been a time when so many nations were needing to talk to each other so much. [...] Never has the need for more widespread bilingualism been greater, to ease the burden placed on the professional few. And never has there been a more urgent need for a global language (Crystal 2003:14).

1.2 ENGLISH AS A LINGUA FRANCA (ELF)

The term “Lingua Franca” stands for a bridge language used by speakers of other languages to make communication possible with one another (Seidlhofer, 2005:339). The term indicates a type of “communication between people who have different first language from the language being used to communicate” (Baker, 2009:569) or, again, as argued by Samarin (1987, in Seidlhofer 2011:7) a Lingua Franca represents “any lingual medium of communication between people of different mother tongue, for whom it is a second language”. If used to ensure communication between groups that do not share the same mother tongue, then any language can acquire the status of Lingua Franca. Yet this definition seems to clearly correspond to the current expansion and use of the English language, which is mastered in almost every country in the world.

Indeed, today, “English as a Lingua Franca” globally offers people from all over the world the opportunity to communicate with each other, regardless of whether they are native speakers or have acquired English as a second or foreign language (Seidelhofer 2011: 7). In fact, it is considered "any use of English between speakers of different first languages for whom English is the communicative medium of choice, and often the only option" (Seidelhofer, 2011:7). In developing this definition, however, linguists have questioned whether or not native speakers should be included in the ELF phenomenon, as most ELF interactions occur between non-native English speakers (Seidelhofer 2011: 7). However, the latter are included when referring to the ELF phenomenon, even though they represent a minority, and their native forms of communication, which differ greatly from those of ELF, are not taken as a linguistic reference related to the phenomenon of English when used as a Lingua Franca since they could contribute to confusion in the understanding of what are the forms used by native speakers and those used by non-native speakers (Seidelhofer 2011:7, Jenkins 2007:2). Echoing Cristopher Brumfit’s observation about the “ownership (that means the power to adapt and change) of any language which rests with the people who use it”, native English speakers (NESs) are likely to contribute far less than non-native English speakers (NNESs) to the way ELF will evolve in coming years (Brumfit 2001:116).

1.2.1 ELF USERS

In order to better understand what is meant by native and non-native speakers, and to better understand the use of English in different countries around the world, it is useful to refer to Braj Kachru’s Three-Circle model (Figure 1), which is a well-known model of the spread of English. The author of the model conceived the idea of three concentric circles of English: The Inner Circle, The Outer Circle, and the Expanding Circle (Kachru 1992). The ‘Inner Circle’ includes those countries where English is a native language for their inhabitants, for example the United Kingdom, the United States. Here English as a Native Language (ENL) means the language that became established through the migration of native speakers of English. The 'Outer Circle' includes countries where English is not the mother tongue, but a language of such importance, for historical reasons, that it is

recognised both as a second language and as an official language for many aspects of the public sphere, for instance in legal, administrative and educational institutions. In particular, these are countries that were part of the British Empire such as India, Nigeria, the Philippines, Malaysia or South Africa. In these countries the English language, that is perceived as a Second Language (ESL) was established through the colonization by English-speaking nations. Finally the 'Expanding Circle' includes those countries where English is widely taught and studied as a foreign language (EFL), for instance China, Russia or Japan (Sedlhofer, 2011:2).

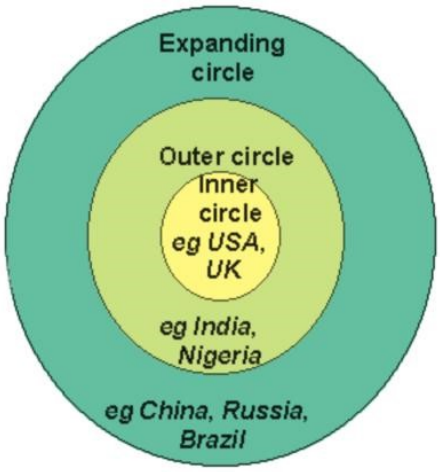


Figure 1. Kachru's "Tree-Circle Model" (Crystal 2003:61)

Another well-known and more recent model is Modiano's "Centripetal circles of International English (1999)". In this model, the centre represents users of English as an international language (EIL), comprising a set of features that are comprehensible to most native and competent non-native speakers of English. The second circle comprises characteristics that may become internationally common. Finally, the outer circle consists of five groups (American English, British English, other main varieties, local varieties, foreign varieties), each with characteristics that are typical of its own language community and are unlikely to be shared by most members of the other four groups.

In this model, however, one sees specific characteristics of each group's speech community that are incomprehensible to most members of other groups. Despite Modiano's model, which is concerned with the diversity of English and understands the spread of the language from a geopolitical perspective, certain

problems persist. These problems relate to the recognition of what falls under the core category and the fact that NSs are not necessarily competent users of the language, thus not always comparable to competent NNSs.

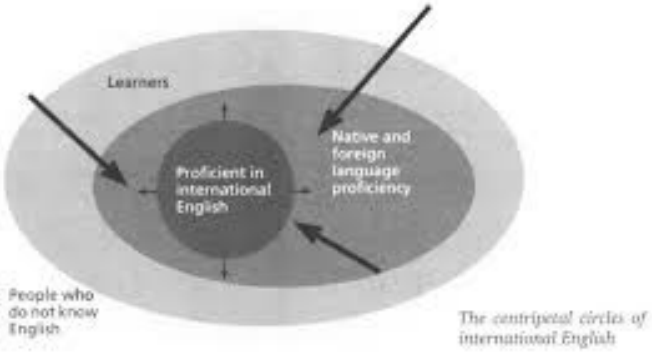


Figure 2. Modiano, M. *English Today* (1999:10)

Nowadays, however, communication in English in general throughout the world has been greatly influenced by the development that ELF has undergone, thus challenging the norms of native speakers, requiring rather "intercultural awareness than native language competence" (Gallo 2022:58). The British Council[2], today, estimates that English is spoken by two billion people worldwide, presenting a landscape that is no longer homogeneous, but characterised by contexts in which interactions from native and non-native varieties are included, that is by the coming together of different languages and cultures in which both the L1 of the interlocutors and English can be found as shared for mutual communication (Gallo 2022: 58).

For this reason, the current scenario of the diffusion of the English language is no longer represented, both by Kachru's model and by Modiano's one. Since in the first case, the NNSs of the Expanding Circle are no longer seen as mere users of rules, the ESL speakers of the Outer Circle as rule modifiers, nor the NSs of the Inner Circle as the sole creators and diffusers of the rules that structure the tongue (Gallo 2022: 58). In the second case, however, reference will no longer be made to a geopolitical subdivision that sees as the protagonist the level of competence possessed by the speakers of the language. This is a consequence of the "paradox of internationalization, that is, the more a language is used throughout the world, the less it is able to convey the vision of the world of its NS, who can no longer be

[2] https://www.britishcouncil.org/sites/default/files/english-effect-report-v2.pdf

considered the sole owners of its correctness (Santipolo 2006) ", therefore also NNSs and ESL users act and will act as creators of rules that can be used in communication in English (Gallo 2022: 58).

1.2.2 EFL vs ELF

A crucial issue while exploring English as a Lingua Franca is to notice the differences between English as foreign language and English as a Lingua Franca.

Seidlhofer and Jenkins have both described the relationship between ELF and EFL to clarify the concept. Jenkins compared 5 key points of ELF and EFL, which can be seen in the table below (Table 1).

ELF	*EFL*
1. Belongs with Global Englishes	1. Belongs with Foreign Languages
2. Difference perspective	2. Deficit perspective
3. Its metaphors: contact and change	3. Its metaphors: interference and fossilization
4. Code-switching seen as bilingual resource	4. Code-switching seen as error resulting from gap in knowledge
5. Goal successful intercultural communication	5. Goal: successful communication with NESs

Table 1: English as a Lingua Franca (ELF) and English as a Foreign Language (EFL) (Jenkins 2014:26).

According to Jenkins, as a first feature, the table places ELF within the concept of Global Englishes as an illustration of the fact that "English is spoken all over the world, both within the same country where speakers share the same first language, and between speakers of different languages/countries" (Jenkins 2014:26). This concept, therefore, allows NNES, who are the majority in the English-speaking world, to be free to determine the type of English they want to use in interactions. From the table, then, it can also be seen that in ELF the dissimilarities with ENL (English as a Native Language) are not automatically seen as errors, but there is a preference on the part of ELF users to use English as a

language to communicate in a way other than ENL. Jenkins also presents the ELF's code-switching feature as an important resource for interactions that occur in multilingual contexts. The phenomenon of code-switching, also known as code-mixing, represents the alternation between two or more languages or dialects, with the use of elements of several languages in a single conversation, which could be seen as an available resource of bilingual speakers (Jenkins 2014: 26).

Finally, an important feature of the ELF, as well as its raison d'etre, is the purpose, that is to focus on the efficiency of interactions in intercultural contexts, thus also including NNESs, rather than focusing on fairness during interactions with NSs. On the contrary, as far as EFL is concerned, it "belongs to the Foreign Languages", since, according to the model of the Foreign Languages, the latter are learned in such a way as to be able to interact with native speakers, and above all, using the language correctly as the native speakers of a language do (Jenkins 2014: 26). Furthermore, in EFL if the phenomenon of code-switching occurs, or if there are ways of speaking different from those used regularly by NSs, then one immediately thinks of a lack of knowledge or mistakes made by those who are learning EFL, considering that, as stated by Jenkins in the last point, the main purpose of the EFL is to have correct and successful interactions with NEs.

On the other hand, Seidlhofer's (2011:18) analysis of the differences between ELF and EFL is schematised in the following table (Table 2).

	ELF	**EFL**
Linguacultural norms	Ad hoc, negotiated	Pre-existing, reaffirmed
Objectives	Intelligibility, communication in NNS or mixed NNS-NS community	Integration, membership in NS community
Processes	Accommodation, adaptation	Imitation, adoption

Table 2: Lingua Franca (ELF) vs Foreign Language (EFL) (Seidlhofer 2011:18)

According to the author, where English is considered and learned as a Foreign Language, people exert themselves to follow the Standard English norms, which are forms of native speakers introduced to the learners of a foreign language through the resources provided by British educational institutions such as the British Council or Cambridge institute. That is, they aim to acquire a level of English identical to that of a NS accepting all the rules and norms of the language, and to use it to integrate into native-speaking communities (Seidlhofer, 2011:17). Instead, the focus for ELF, also echoing the claims of Jenkins (2014:26), is not the 'nativelikeness' but rather an international intelligibility and effectiveness in intercultural communications, thanks to an adaptation of its rules and forms to the need to the speaker. What happens is that the participants gauge a level of language at which they can operate, ad settle on ad hoc, pro tem norms that are adequate to the task and commensurate to the command of the linguistic resources they have in common (Seidelhofer, 2011:18).

It would be futile for ELF interactants to try to follow the norms of standard English when interactions are carried out by NNESs. On the contrary, in these contexts, adapting to the conventions of the native speaker can be counterproductive in Lingua Franca interactions, especially when idiomatic expressions are inserted or opaque language is used, i.e. difficult for NNESs to understand (Hülmbauer in Pitzl and Ruth 2016:50).

> Surprisingly, native speakers of English are not the most successful communicators in multilingual contexts: they are said to be difficult to understand and lack the communication skills of non-native speakers. Apparently, native speakers do not have to learn English as a second language, but must learn to speak English with non-native speakers (LINEE 2010, 36).

The use of ELF, therefore, does not imply a predefined form of English, but rather the use of linguistic resources adapted to a particular communicative purpose, which are negotiated during conversation. "On the one hand there is a common language at the macro level, which on the other hand has to be actively adapted and accommodated among participants at the micro level" (Hülmbauer 2011 in Pitzl and Ruth 2016: 51). Indeed, as Hülmbauer suggests (2011 in Pitzl and Ruth 2016: 49-50), there is no direct relationship between grammatical correctness and

communicative effectiveness or mutual intelligibility, where one guarantees the other. Reciprocal intelligibility can be achieved, for instance, by repeating important elements, paraphrasing, clarifying difficult-to-understand speech points, using and creating one's own idiomatic expressions or using discourse markers (such as 'You know') to introduce an important new topic (Jenkins 2011: 293-294).

1.3 ELF LINGUISTIC FEATURES

Interactions using English as a Lingua Franca occur predominantly between NNSs, whose norms are set by its users rather than native speakers. As a result, ELF communications are often very hybrid, that is they have many characteristics that may be different from English used by NSs. I will now present a brief description of some of the characteristic linguistic patterns occurring in ELF related to this phenomenon, which are visible in the famous Vienna-Oxford International Corpus of English (VOICE) created and subsequently analysed by Jennifer Jenkins and Barbara Seidlhofer. This is the first computer-readable corpus that captures spoken ELF interactions, which are recorded conversations in ELF that occur naturally, without any script and mostly face-to-face covering a wide range of first language contexts (professional, educational, informal), functions, roles and relationships of the participants, which are, then, transcribed by experts and archived in the form of a corpus. The aim of this corpus project is to pave the way for a deeper and large-scale linguistic description of the contemporary use of English that will be accessible to language researchers worldwide. In particular, the linguistic fields of lexicogrammar, phonology and pragmatics will be presented below.

Concerning lexicogrammar according to the VOICE research:

- Omission of the 3rd person singular -s in the present tense
- Interchangeable use of relative pronouns *who* and *which*
- Incorrect use of definite and indefinite articles
- Interchangeable use of countable or uncountable nouns
- Use just the verb stem (no -ing form) in constructions
- Use of ‘isn’t it?’ or ‘no?’ as a universal tag question

Seidlhofer (2004) suggests that these characteristics do not cause misunderstanding during NNESs-NNESs interactions. Kuo (2006:216) argues as

well, that these frequently occurring features are considered grammatical errors in ENL, whereas in the use of ELF they are accepted, until communication can no longer continue due to misunderstandings.

Concerning phonology,

- Substitution of the interdental fricatives /θ/ and /ð/ by other consonants in case of difficulties in pronunciation, for instance /t/ or /s/ for /θ/ and /d/ or /z/ for /ð/
- Rhoticity, that is the final syllable /r/ is not dropped
- Lack of flapping, that is the intervocalics /t, nt/ are always pronounced as [t, nt] and not as [ɾ, ɾ̃]

These traits listed above are collected in Jenkins's "Lingua Franca Core" (LFC), present in her book "The Phonology of English as an International Language". The LFC presents the phonological linguistic characteristics of the ELF, which the author recommends to ELF users with the aim of making communication intelligible and unifying NNSs in the use of English as a Lingua Franca. It is also considered to be a very important resource in teaching; traditionally, in fact, teachers take the LFC as a reference point to focus on the phonological features presented by Jenkins for teaching language pronunciation and avoid speech features, sounds or accents that might cause difficulties in learning by non-native speakers of a specific language, in this case English.

Finally, concerning pragmatics, Jenkins (2011:293) suggests some strategies for the approach of interlocutors during ELF communication to avoid or resolve misunderstandings since, as is well known, in ELF interactions people prefer to ensure understanding rather than to speak perfect English. And they are:

- Repetition
- Paraphrasing
- Creating new idiomatic expressions

The purpose of the aforementioned linguistic features, which are the main and the most visible, is to make it possible for non-native speakers to understand the content of an ELF interaction, as well as to adapt the use of language according to everyone's different linguistic and cultural background and situation.

CONCLUSION

Undoubtedly, English today holds the status of a world language and, moreover, its Lingua Franca role makes it the most widespread and widely used means of intercultural communication (Hülmbauer 2011 in Pitzl and Ruth 2016: 43). The ELF phenomenon has arisen as a cause and consequence of globalisation, which has affected different spheres of everyday life, spheres that are increasingly multidirectional and whose boundaries, whether political, economic or socio-cultural, have become uncertain. Thus, even at a linguistic level, centre-periphery models can no longer capture people's communicative realities (Appadurai 1996 in Pitzl and Ruth 2016: 44). Currently, most ELF researchers take a broad view and include all users of English in the definition of ELF, regardless of the circle of use from which they come. ELF is thus not a matter of following the norms of a particular group of English speakers, but a mutual negotiation involving adaptations by all (Jenkins 2009:202).

However, in the case of native speakers, the number is limited in order to ensure that they do not influence other non-native speakers, even unknowingly, with an excess of ENL norms, putting them under pressure and pushing them to follow a native English model since, from this point of view, ELF users would not be destined to have intelligible communication. ELF is thus a matter of mutual negotiation involving adaptations on everyone's part. On the one hand, there is an ELF 'common ground' that inevitably contains linguistic forms that it shares with ENL; on the other hand, it has forms that differ from ENL, born out of contact between ELF speakers and the influence of the first languages of ELF speakers on their English (Jenkins 2009:202). This local variation represents the possibility for users to adapt their speech to make it more understandable and suitable for their specific interlocutors. According to Jenkins (2009:202), this can take place, for example, through code-switching, repetition, echoing elements that would be considered errors in English, avoidance of local idiomatic language and paraphrasing (cf. Cogo and Dewey 2006; Kirkpatrick 2008).

CHAPTER TWO

MEDICAL ENGLISH AS A LINGUA FRANCA (MELF)

INTRODUCTION

English has become the international Lingua Franca of the 20th century, thanks to the unstoppable increase in the number of people communicating across boundaries. Therefore, people have become more and more reliant on the English language. Today, its dominance can be observed in the fields of international business, banking, technology, and also communications, films, and news broadcasting, as English is the language of the internet, advertising and international conferences. By the same token, the fact that English plays a leading role in the international medical community is widely shared by many scholars (Sliosberg 1971; López and Terrada 1990; Navarro and Barnes 1996; Gutiérrez Rodilla 1997; Navarro 1997; Van Hoof 1999; Munday 2002 in Ruiz Rosendo 2008:233). Indeed, over the last few decades, English has become the language par excellence of communication in the field of health sciences and medical science, replacing, for example, French or German, and thus becoming a kind of common second language for doctors and researchers and, in general, for all those involved in scientific disciplines (Navarro 1997). Inevitably, therefore, there has been an acceptance and recognition of a current phenomenon within the scientific community and within society, namely that of current scientific 'monoligualism' (Ruiz Rosendo 2008:233).

The supremacy of English is to be found in almost all medical journals, but English is also considered a bridge language in oral communication between professionals at international meetings, when they involve research and the practical field to facilitate communication and understanding between people whose mother tongue differs from English. This development has some indirect consequences, which according to Navarro [3]are: scientific dependence and standardisation of thinking occurs, as research methodologies, concepts, ideas and

[3] https://cvc.cervantes.es/obref/congresos/valladolid/ponencias/nuevas_fronteras_del_espanol/1_la_traduccion_en_espanol/navarro_f.htm

reasoning are determined by international journals published in English and in whose editorial boards English-speaking authors are by far in the majority (75%). Consequently, there is a global tendency to choose concepts, topics, and lines of research based on those followed in the United States, which leads to intellectual monolithism. The language barrier distinguishes medical science published in English as a high-quality science and, conversely, that published in the native language of researchers perceived as secondary. Consequently, there is a tendency to believe that an article written in English is better than one written in another language.

The jeopardisation of the work of scientists who publish in their mother tongue, as they do not always translate or create neologisms and technical terms but report them in their work as they are found in the literature, which is mostly in English. This hegemony of English is to be found not only in the specific field of medicine but is consolidated in general language use as it is strongly regarded as the main global language for general and not only medical communication (Munday 2002). Nonetheless, its status as the most widely used Lingua Franca in science and medicine fulfils the need for a global language (Keresztes 2009: 56) so that more and more people are able to communicate, even across borders, with a common language code. The latter, as will be seen later, through borrowings, calques, neologisms, etc., brings the presence of English to other medical languages. Even if most of the terms coined in English could be translated, scientific literature is written in English and this language has dominated other languages, so it would be senseless to oppose a fact that, nowadays, must be accepted as it facilitates international communication and scientific progress, as well (Gancedo,1994).

Finally, a very important note to bear in mind is that, as an emerging site of study within the broader field of ELF, important premises need to be made in this specific field of research, whose reference literature is very limited. As the authors Tweedie & Johnson state in their very recent handbook *Medical English as a Lingua Franca (2022)*, it was necessary to proceed with a certain level of tentativeness in order to provide a theoretical basis for English as a Lingua Franca in the medical field, and likewise to propose definitions, which are certainly

preliminary and will inevitably be the subject of further study and revision in the future.

2.1 HISTORY OF MEDICAL ENGLISH

The English language is regarded as a fundamental tool that can open linguistic gates to international business, technology and science and, conversely, in a world dominated by modernization the lack of this knowledge thwarts this possibility of development (Burchfield 1985) underlining the fact that if literate and educated people do not know English, even at a basic level, they can be defined as linguistically deprived (Keresztes 2009:56). Currently, to communicate, English is the most widely used Lingua Franca in the field of sciences and among them in medicine, if not the most widely adopted one. “English as become so dominant as the international language of science, especially of scientific publications, that its use seems to be necessary if one wants to be read or discussed outside of one’s country” (Ammon, 1994 in Keresztes 2009:59).

Although only the last 50 years are to be considered crucial for the attainment of English language proficiency/dominance in over 60 countries (Crystal 1997). This is evident from the five periods that can be identified in the history of the language of medicine in Europe (Fehér 1997). In antiquity, it was the Old Greek that held the linguistic dominance in the medical science, around 500B.C., and only to some extent did Latin, around 100 B.C., overtake it, with the gradual rise of the Roman Empire (even though the Hellenistic influence was still very decisive among physicians) (Dirckx 1983). Later, in the Middle Ages, at least three languages were widely used in the field of medicine, but there was no Lingua Franca (Keresztes 2009:59). Besides Greek, which was the main language of medicine, Arabic prevailed in the Islamic world, where medical sciences were highly developed. Whereas in Western Europe, Latin predominated in every scientific field, indeed at that time several medical works were translated from Greek and Arabic into Latin (Maher 1986). Latin, during the Renaissance, became the language of the education and it was used as the only language of the medicine as well. Especially in Europe where many of the ancient Greeks’ and Romans’ observations and breakthroughs in the medical field were recorded almost exclusively in Latin, except for some publications in German by Paracelsus and Paré (Fehér 1997:2658). Latin

maintained its role as the European language of printed scientific books, until the mid-17th century, but already for a couple of centuries medical articles were translated into vernacular languages (Keresztes 2009:59).

The dominance of Latin in the culture can be seen in the adoption of Latin expressions and the alternating use of both languages. Borrowing from Latin and switching to Latin occurred frequently in the past by the authors of scientific writings, a phenomenon that led to Ancient Greek and Latin still being at the basis of most scientific terms. After the French Revolution, the most widely used language for medicine, for science but also for culture was French (Navarro 1996). This role was later filled by German and English, as the publication of medical journals began to play a role in the nationalisation of medical communication (Taavitsainen 2006: 644). In the 20th century, American surgeons also spent training periods in leading European clinics to acquire a practical knowledge of German (Benfield and Howard 2000). The prestige of German as the main language of medicine gradually disappeared, particularly after the World War II, while at the same time it could be observed how the growing popularity of English led it to become the language of medicine (Keresztes 2009:59).

2.2 ELF vs MELF

Although the MELF has much in common with the vast amount of established knowledge on ELF, it differs from it in several important respects. MELF may be the most prone to the process of standardisation, regulation and codification, precisely because of its nature of insisting on standardisation, i.e., enabling and enforcing its regulation (Tweedie & Johnson 2022). However, this contrasts with the variability, fluidity and emergence typical of ELF interactions that occur in other domains on a daily basis around the world, and which are due to the multitude of boundary factors that enable their existence. In this case, in the field of medicine, the totality of interactions aims at the accurate and unambiguous transmission of information, as the consequences of an erroneous communication could be disastrous. As will be made clear later, MELF is used in practice mainly in special circumstances, such as multilingual language contact environments due to the migration of workers, who work and interact daily with languages other than

their own for a period of months and sometimes years. These factors just mentioned, added to the time pressure and established protocols governing interactions, mean that the MELF does not share the same phenomena of language regulation and standardisation (as far as studied so far) with the ELF (Tweedie & Johnson 2022: 1.4.2).

In contrast to most ELF interactions (Jenkins 2015), in healthcare, there is an electively fixed community in which medical practices are carried out, and in which procedures and processes are controlled by formal regulatory organisms, divided into three levels: local, national and international. The domain of the MELF, however, can go against everything that claims localisation. In fact, we can find demonstrations by users of the MELF that indeed recover forms of local use (Canagarajah 2005), but which are now shaped by constraints of global norms from which they cannot escape.

It is impossible not to mention, therefore, one of the main destinations of migrants in the health care sector, namely the countries of the Gulf Cooperation Council (GCC; International Relations and Security Network, 2009), which present themselves as a particular scenario in which frequent and protracted contacts between ELF users occur, thus allowing further stabilisation of MELF norms. Indeed, the United Arab Emirates (UAE) and Qatar with their progress, have brought a large influx of temporary migrant workers, estimated at 88% of the UAE's population (Boyle, 2012) and 85% of Qatar's (Paschyn, 2012), in which English is the second or third language for many expatriate workers in the region (Tweedie & Johnson 2018:5). Furthermore, in this context the duration of a community and the frequency of communication within it could influence its inclination towards the formation and introduction of normative processes (Mauranen 2018). Obviously, where interactions of MELF take place, this is not the only field in which normative processes such as ELF standardisation and regulation can be observed and studied; there are others e.g., one can mention air traffic control, or again Mauranen proposes the European language community in Brussels after Brexit (2018).

2.2.1 INSTITUTIONAL DISCOURSE AND ITS HIGH-RISK NATURE

One of the main features of these normative phenomena influencing MELF is the institutional discourse, which has so far been less analysed in the ELF (Tweedie & Johnson 2022: ch.1). Institutional discourse is distinguished by the structure of its word exchange systems (Hutchby and Wooffitt 2008), in other words within its participants are typically embedded in a relatively structured system of pre-assigned turns of phrase with question-answer sequences. And this is what can be observed in medical contexts, where this turn-taking system tends to be articulated in order to achieve useful and precise goals, such as gathering information to hypothesise a correct diagnosis (Tweedie & Johnson 2022: ch.1). The doctor or health worker conducts the interview, while the patient is supposed to answer the questions. Usually in this type of interaction between professionals and patients, there would be no formal constraints that do not allow the patient to initiate an interaction with new questions or to expand their answers with new issues, but the questions asked by professionals circumscribe the type of answers they can receive from patients thus respecting the typical disequilibrium of the exchange (Heath 1992). Indeed, given that exchanges in the medical field 'play a social role - the provision of care and the maintenance of public health - and are therefore regulated by legal and social norms' (Bigi and Rossi 2020:18), one could almost consider it a requirement that they take place in a formalised and pre-established manner (Tweedie & Johnson 2022: ch.1).

MELF also stands out because, unlike the vast knowledge that ELF scholars have and how related interactions can unfold, its field of research is very limited, so much so that the field of medical communication is unparalleled. What is certain, however, is that within it the communication that must necessarily be effective is considered of great importance, as an ineffective communication could lead to harmful or fatal outcomes. Possible "language barriers" that could lead to poor communication efficiency in the medical-health field are, for example, time pressure, the inadequate way in which questions are asked to patients or other professionals, complicated or incomprehensible medical language, deficiencies in the organization or system or fear of legal problems (Tweedie & Johnson 2022:1.2). The literature often refers, albeit with an inadequate term, to "Limited English

Proficiency" (LEP) and with it also the challenges it can present when administering specific and effective treatments to patients.

Another peculiarity of MELF is the high risk of exchanges (Tweedie & Johnson 2022:1.2), in fact they could compromise people's lives and even lead to death. Of course, even commercial or academic exchanges carried out in English as the only Lingua Franca for mutual understanding, could have negative and risky consequences, but life or death problems rarely arise, on the contrary, "names or dosages of drugs misunderstandings or misdiagnoses due to linguistic inaccuracy, it can ". In this regard it has been stated by medical researchers that patient safety (Divi et al. 2007) could be compromised and serious medical events could also occur more frequently (Cohen et al. 2005). At this point, one may therefore ask, given that in the MELF research field high precision in communication is required, whether it occurs both between professionals and between patients and doctors or health professionals, whether the typical ELF "Let it pass[4]" strategy developed by Firth in 1996, it can be suitable for hospital or clinical scenarios where precision, delicacy and emergency are typical

2.2.2 NON-VERBAL LANGUAGE AS AN ESSENTIAL FEATURE

The most important thing in communication is to hear what isn't being said. (Peter Drucker in Ratcliffe 2016)

A further aspect of MELF that could expand ELF knowledge is concerning non-verbal language forms as elements that are part of ELF communication, since, as Matsumoto (2019: 569) points out, in the study of ELF "few researchers have conducted in-depth analyses of non-linguistic interactional elements in a way that treats them as integral to ELF communicative strategies". The latter states, again, that non-verbal language in ELF interactions has been characterised as an additional element to communication, but not as part of the "multimodal whole" (Bezemer and Kress 2008:166) that is communication. Non-verbal forms in medical communication in general, such as gestures, postures, eye-contact and tone of voice

[4] The "Let it pass" strategy indicates all those situations in which "the listener (…) lets unknown or unclear action, word or expression 'pass' on the (common sense) assumption that it will become clear or redundant as the speech progresses" (Firth, 1996:243) without stopping or signalling the interlocutor what might be wrong or unclear.

(Tweedie & Johnson 2022:6.4), play an important role in health care communication, as they promote higher quality of services and greater safety, as they help prevent misunderstandings (Frankel 2012 in Tweedie & Johnson 2022:6.4)."Gestures and other non-verbal signs can contribute significantly to avoidance of non-understanding in MELF communication" (Ting and Cogo in press). Indeed, when assessing patients' health, or during medical examinations, to understand patients' medical conditions, a physical demonstration is required in addition to the verbal explanation provided by the client, which is then verbally confirmed by the medical professionals and finally also by the patient, thus allowing communication and assessment to continue successfully. Tweedie and Johnson (2022:6.4) state that non-verbal communication to accompany the exchange of medically necessary information in hospital or clinical settings is of great importance and effectiveness, because at the same time it leads to further developments in medical education in contexts where mutual understanding is due to English as the Lingua Franca, and allows for the reduction of possible misunderstandings, as well.

It may be assumed that the research literature on medical communication refers to a linguistically homogeneous reality as far as medical professionals are concerned, who only find difficulties when they have to deal with their patients, who do not have language skills up to the standard of comprehensive health care. However, in the actual fact, these language difficulties also affect foreign doctors, nurses, or healthcare assistants, who find it difficult to communicate, and thus also to work, with their colleagues (Tweedie & Johnson 2022:2). Generally, one encounters these language barriers in medical interactions from a practical point of view, which are studied theoretically in an attempt to improve and increase the possibility for all to have access to care, but also simply in the context in which healthcare is provided in linguistically non-homogeneous societies. (2022:2.1)

2.2.3 THE MAIN LINGUISTIC FEATURES DUE TO LANGUAGE CONTACTS

The concept of 'similects' as developed by Mauranen (2012; 2018) is useful for understanding ELF, in general and also in medical contexts. English, given its

domain, might have relative contact with many of the world's languages and enter into a state of contiguity with them (Mauranen 2018:9), it is therefore understandable to observe in ELF interactions the linguistic influences arising from other L1s, for example in vocabulary use or pronunciation. Manglish (for 'Malaysian English'), Chinglish (for 'Chinese English') and Spanglish (for 'Spanish English') are ways often used in informal language to describe this phenomenon. According to Widdowson (2004:361), ELF communication does not penalise the quality of communication that takes place in standard English, but on the contrary makes it more effective as it "allows interlocutors to express themselves without conforming to norms that represent the socio-cultural identity of other people".

However, specifically in the medical field, Tweedie and Johnson observed how, according to testimonies of various doctors throughout their careers, it is believed that they are not good communicators in their profession: "We [doctors] do not seem to be good communicators" (Tongue, Epps & Forese 2005:652). However, according to studies to date, there are many other elements that could threaten the efficiency and success of doctor-patient communication, including "excessive medical jargon (Deuster et al. 2008); ineffective interrogation techniques (Roter et al. 1999); unequal communication and background knowledge between doctors and patients; avoidance of empathy by doctors due to time pressure and workload (Maguire & Pitceathly 2002); fear of litigation, among others (Ha & Longnecker2010)".

As concern language, I will now take a general look at the most visible features of the influence of ELF in others European medical languages, but first it is worth mentioning what the peculiarities of medical and scientific language are. Scientific language is distinguished from other languages by certain lexical, grammatical, semantic and stylistic requirements: universality, precision, objectivity, rigour, absence of expressiveness and emotionality, lexical clarity and monosemy to avoid ambiguity and confusion (Ruiz Rosendo 2008:235). Simultaneously, it must avoid long sentences and literary figures, it must be natural and elegant with frequent repetition, since the main goal is accuracy and clarity. Medical language, therefore, should fulfil these features, but in recent decades it has developed a number of linguistic phenomena that lead to a loss of accuracy and

clarity in the message, which is one of the most important obstacles to medical education and research (2008:235). At a lexico-semantic level, the reason why most elements remain foreign is the structure of the syllables or the phonetics of the receiving language that is at odds with the English language, the difficulty in translating as adequately as possible, the economy of the -ing form that is very common in English, or the lack of relationship between the spelling of a word and its pronunciation (Alcaraz Ariza & Navarro 2006: 755). In some cases, the loanword is considered native after a large degree of adaptation in the receiving language, thus subsequently adapting the foreign word to the rules of the loan word, for instance *standard* would become *estandar* and *stress* would be *estres,* according to the followed in Spanish, for which a written term should reflect its pronunciation.

The English language also influences medical language when it comes to abbreviations (2006:755), for instance the phenomenon of initialisation, which in some cases almost completely replaces the corresponding full word (see *corticotropin,* more likely known as ACTH*)*, or the phenomenon of acronyms, which are formed on the basis of English terms, thus being universally comprehensible, are widespread.

DNA (deoxyribonucleic acid)
RNA (ribonucleic acid)
MRI (magnetic resononance imaging)
PEEP (positive and-expiratory pressure)

Table1. Lexico-semantic level: initialism and acronyms (Alcaraz Ariza & Navarro 2006:755-756)

Linguistic transfer can be effective, when semantic borrowing occurs in response to a request to express a new concept from another country, and the adopted word/phrase adapts to the phonetic-phonological and lexico-semantic environment of the recipient language (2006:756). The new concept may be then expressed through a 'semantic borrowing' or through a 'linguistic calque', which are widely used in medical language and literature, even though they can be considered 'false friends' (2006:756), that are words with the same spelling but

different meanings. A good example of this phenomenon is the Spanish verb *asumir* which, in addition to its original meaning of accepting, assuming, now has the meaning of *to assume* as well, precisely because of the influence of the English language, or the Spanish noun *evidencia*, which thanks to the influence of the English word *evidence*, it has taken on the meaning of proof, testimony.

At a syntactic level, at the level of grammatical structure, medical language is less influenced by Anglicisms than at a semantic-lexical level. In fact, the influence of the English language is considered the main reason for the increasing use of the passive voice instead of the active voice with pronominal or reflexive forms (2006:756). This is because, first of all, the passive voice is not characteristic of languages for specific purposes because they only evolved in the centuries following the second half of the 20th century (Luiz Rosendo 2008:240). In the other predominant languages, classical and modern, before the predominance of English as an international language, the use of passive verbs was not common. Secondly, Anglo-Saxons themselves point out the exaggerated use of passives in their language; and thirdly, their use, i.e. dissociating the semantic agent from the syntactic subject, turns the text into a less precise document, which is contrary to one of the main characteristics of scientific language, namely accuracy. Another feature derived from the influence of English is the overuse of gerunds (Luiz Rosendo 2008:241; Alcaraz Ariza & Navarro 2006:756), with a sense of posteriority in medical language, English also seems to have encouraged the use of nouns in the attributive form, where in other languages, e.g. Spanish, adjectives or prepositions are required, and its greater flexibility of adverbial position would also have led other European languages to resort to new collocations of adverbs and adverbials.

Campaña anti-aborto **instead of** ***campaña antiabortista***	**From** ***anti-abortion campaign***
Depresión posparto **instead of** ***depresión del posparto***	From *postpartum depression*
Linfoma no-Hodgkin **instead of** ***linfoma no hodgikiano***	From *non-Hodgkin's lymphoma*

Table 2. Syntactic level: attributive use of nouns due to English influence (Alcaraz Ariza & Navarro 2006: 757)

Other morphological and syntactic phenomena can also be noted, such as the hyphenated joining of affixes and nouns to create compounds, which is always an influence of the English language (Ruiz Rosendo 2008:241), through, for instance, anti-neoclassical and pre- or post-temporal or sequential (Alcaraz Ariza & Navarro 2006:757). English, in fact, very often uses hyphenated adjectives or nouns, whereas in Spanish or other European languages this was not so common and went against linguistic rules. In Spanish for example sometimes:

Anti-inflamatorio **instead of** ***antinflamatorio***	**From** ***anti-inflammatory***
Anti-ulcerosos **instead of** ***antiulcerosos***	From *antiulcer agents*
Pre-test **instead of** ***pretest*** **or** ***prueba previa***	From *pre-test*
Post-test **instead of** ***prueba posterior*** **or** ***postest***	From *post-test*

Table 3. Typographic level: Hyphenation (Alcaraz Ariza & Navarro 2006: 758)

The wide presence of sources written in English and reference style manuals for the writing of academic papers, which are mostly derived from translations of English documents, has led some of the preferred English attenuated rhetorical models to be imitated by scientists all over the world (Salager-Meyer 2003). The typical English tendency towards hedginess can be observed in the epistemic use of modal auxiliary verbs in other European languages or in the presence of modal-related adjectives, adverbs or nouns e.g., in Spanish, the use of *puede(n)* for 'can/may' or *podrìa(n)* for 'could/might' (2006:758). Along with the latter, one can also note the widespread tendency to switch responsibility, which makes it possible to focus on the information transmitted and thus 'defocus' the researchers or readers participating in the communicative act (2006:758).

Finally, as far as a phonetic level is concerned, phonemic imports are not the result of language contact situations, but, in this case, the original English phonemes are replaced in all cases by native phonemes, which are approximately corresponding and which follow the structure and rules governing the native language. For example, in Spanish, words beginning with 's' followed by a consonant do not exist, so even when we are faced with such words and the spelling does not change compared to the imported English word, there will be a different pronunciation, such as the word *screening* being pronounced /es'krinin/. The system, therefore, is modified, as in some cases phonemic redistribution caused by Anglicisms may occur (Alcaraz Ariza & Navarro 2006:757).

The almost exclusive dominance that English holds in scientific publications and content published on the web have made it a privileged vehicle for sharing information worldwide. It is thus that much of the terminology borrowed from medical English has been accepted in other target languages and at the same time, especially in the field of science, seen as a consequence of the advancement of medicine, which needs an appropriate increase in its vocabulary to facilitate fluent scientific communication (Alcaraz Ariza & Navarro 2006:758).

2.2.4 LANGUAGE BARRIERS

> Miscommunication is understood to be the main reason for medical mishaps (Khairat & Yang 2010).

The hurdles described so far regarding medical communication only refer to the mutual doctor-patient relationship. Health care in general, however, is also delivered to people through a complex network of interactions that take place between different medical fields (there are an estimated more than 50 specialisations and sub-specialisations - Leape and Berwick 2005). Naturally, such intricacies could jeopardise the efficiency necessary for inter-professional communication; it is also understandable that the phenomenon of migration of medical workers and the linguistic differences that this assumes can also be obstacles (Tweedie & Johnson 2022:1.2).

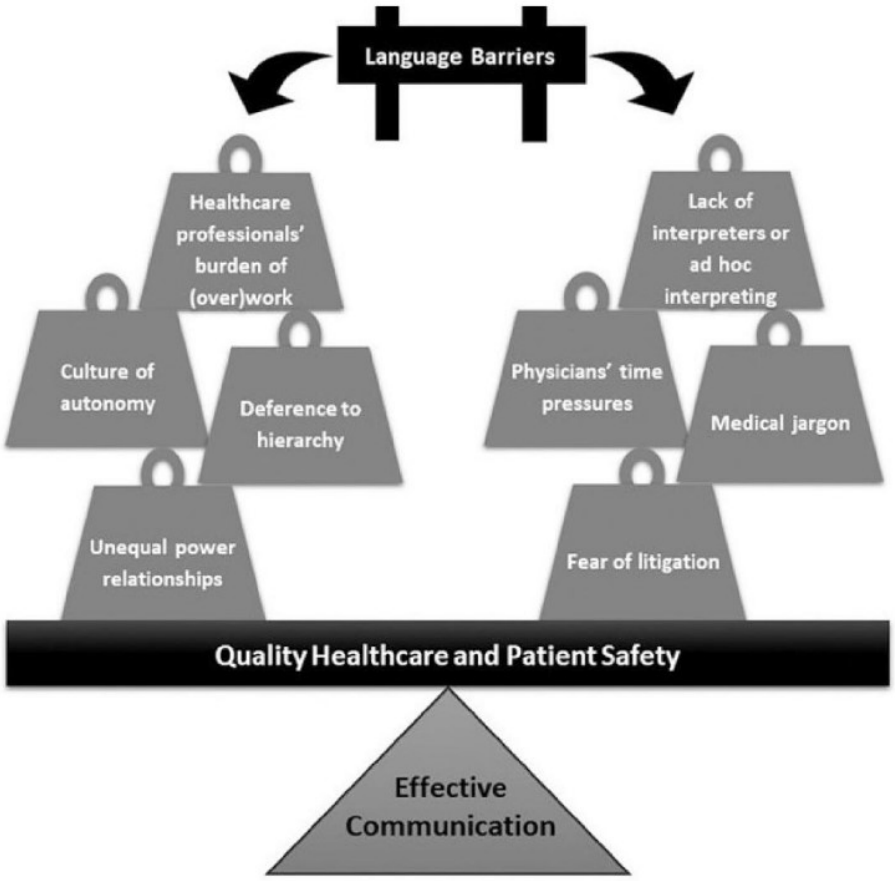


Figure 3. "Layers of complexity in healthcare communication: a delicate balancing act" (Tweedie & Johnson 2022:1.2)

According to some data, Foronda et al. (2016: 36) state that "Ineffective communication in health care results in delayed treatment, misdiagnosis, medication errors, patient injury, or death". At the basis of this previous statement there is the analysis conducted by CRICO Strategies, a division of Harvard Medical Institutions that is responsible for the administration of a large database of malpractice cases in the United States. Their analysis shows that, with reference to the 2015 annual baseline, out of 7,149 patients who were harmed by miscommunication, 88 % of them suffered injuries of medium to high severity, even leading to death, and 38 % of them never heard from their patients again, thus leading to a breakdown in communication between professionals and patients, as well as receiving poor information about the patient's health or medical condition.

According to the Joint Commission[5] in 2015, lack of communication with physicians and healthcare staff about important patient information and hierarchies in the medical staff causing intimidation, were the main causes for URFOs, i.e. foreign objects unintentionally left inside patients such as instruments, catheters, needles, gauze and other objects. However, no previously conducted analysis reports language or cultural differences specifically caused by the migration of healthcare professionals as the causes of failed communication; although there is an increasing recognition of this reality by healthcare researchers (Meuter et al. 2015), "the ultimate goal of any doctor-patient communication is to improve the health and medical care of the patient" (Ha & Longnecker 2010: 38). The literature on ELF in the medical field, although generally very limited, provides a great amount of information on what are described as 'language barriers', although from the point of view of applied linguistics, this definition is erroneous, tending to override features that relate to language abilities and their functions (such as the ability to clearly and comprehensibly express one's symptoms) (Tweedie & Johnson 2022:1.2).

In addition to the various negative repercussions mentioned above, language barriers, in general, may cause further complications such as: they impair understanding of the name and use of medicaments (Wilson et al. 2005); they lead to increased length of hospital stays (John-Baptiste et al. 2004); they cause high hospitalisation rates (Hampers et al, 1999) and increase the likelihood of being readmitted to hospitals (Karliner et al. 2010); they induce incorrect and inadequate use of resources (Hampers & McNulty 2002); they increase the occurrence of serious medical events (Cohen et al. 2005). Thus, on the whole they threaten the safety of health and patient care due to low-quality health care. A potential solution, which could reduce the risk of difficulties and problems caused by inefficient communication within healthcare contexts, could be to resort to professional figures specialised in healthcare contexts such as interpreters (Tweedie & Johnson 2022:1.2). In fact, through extensive studies, it has been found (Karliner et al 2007) that in hospital or clinical settings, the use of an interpreter would bring many

[5] One of the largest and most prestigious accrediting bodies in the world. It is a voluntary accreditation process through which a third party certifies and guarantees that a healthcare organisation meets specific standards.

advantages, including the provision of various services in the language of preference and the consequent increase in patient satisfaction, the decrease in potential communication failures and, overall, the improvement in the quality of healthcare offered in multilingual environments (CHIA 2002). Yet, it seems that this is a scenario that could never come true as the available resources concerning interpreting are not sufficient to cover the number of languages to be translated in the various healthcare organisations (Karliner, Pérez-Stable & Gildengorin 2004); the need for an interpreter is never fulfilled in one go, on the contrary it would be needed for several appointments and several medical visits; finally, the patients' health conditions, possibly serious or contagious, would also make it impossible to resort to this valid solution (2022:1.2). Therefore, patients stated that they either communicate personally with healthcare staff or doctors, or ask friends or family for help, or even 'barely communicate' with them (Schenker et al. 2011:712).

In successful communication between patients and doctors, who do not share the same mother tongue, it is important for doctors to also have good clinical and interpersonal skills (Cox and Li 2020). Attempts have been made to identify some remedies to define 'Limited English proficiency', which has so far been inadequately described (Tweedie & Johnson 2022:1.2). Roberts and other scholars (et al. 2005) have drawn up a series of characteristics that would cause errors in communications between doctors and patients, which are, for example, the pronunciation, accent and intonation of words, the vocabulary and grammar used within the discourse, the lack of general knowledge of the context and finally 'presentation style' (2022:1.2). The latter refers in particular to the way of organising the discourse, the overload of information and arguments offered to the patient, the overlapping or interruption during a discourse; this was indicated as the characteristic that most of all makes it difficult for patients to understand the possible presence of a problem, ending up relating to and discussing with professionals without knowing exactly why and what the main topic of the dialogue is.

According to Pitzl, “ELF is essentially characterised by its linguistic variability, flexibility and creativity” (2018: 15) as it is characterised by “a high degree of situational adaptability that leads its linguistic forms to be locally

(re)coined and (re)adapted" (2018: 19). In contrast, MELF is characterised by several elements that deviate greatly from Pitzl's assertion. Foremost among these relate to forces arising from above, which in a sense, limit the flexibility and local variability of linguistic forms. These limitations might derive, for example, from managers or supervisors of nurses, tutors or the hospital administrator who has to get in touch with the insurance agency, all of which require suitable and typical terminology (Tweedie & Johnson 2022: 1.4.2). For instance, if one considers a dialogue in which both the doctor/nurse and the patient are non-native English speakers, and therefore the interaction will have to take place in English for mutual understanding, one can see how there can be a non-observance of the rules generally used in standard English if this facilitates communication, but at the same time, during the assessment of the patient's physical condition, typical language will have to be used, with respect to which the professionals cannot avail themselves of the freedom to be creative or flexible in language. It can also be seen in the dialogue below where a nurse whose L1 is Malayalam is performing a neurological examination on a stroke patient:

> "Nurse: OK. So you're a 60-year-old feral patient, I can see that your skin colour is appropriate for your ethnicity and your facial symmetry is appropriate as you speak. And you're awake and alert and nutritionally you look fine and uh, your posture is um, your posture is erect. Good? And you are comfortable and cooperative. Your facial expression and uh, it's appropriate to the situation and the speech is clear and understandable to me. Um, [patient's name] I need to check how you are walking. Can you please walk for me a few steps? Within this conversational turn, an example of what we have come to describe as 'biomedical thinking aloud', we can see features of Nurse Johild's utterance that are consistent with those of other ELF users: for example, the flexible use of determinants (can you please walk a few steps for me)" (Tweedie & Johnson 2022 chapter 1.4.3)

In fact, the nurse here pronounces the article 'a' before 'few steps', where there should be none, yet at the same time, she makes use of language typical for medical assessment of patient conditions, such as facial symmetry; posture is upright; awake and alert; comfortable and cooperative (2022:1.3.4).

2.3 ROLE OF ELF IN HEALTH AND SCIENCE RESEARCH

According to Weinreich, the English language is the only useful medium for accessing an increasing amount of information in the medical field: 'Everything that is not in English is simply disregarded' (Keresztes 2009:60). English as a Lingua Franca is used as a means of international communication both with written and

oral, used in the field of health for research, study, but also for national meetings by medical professionals (Gunnarsson 2001). For instance, at both the European Society of Cardiologists Conference in 2007 and the 27th European Stroke Conference in 2008, English was the only language spoken during the conference and even at the latter conference English is prescribed as the official language. In both cases, the use of English, however, is taken for granted, as both conferences were held in officially non-English speaking countries (i.e., Austria and France).

According to the International Federation (for Information and Documentation) (FID), almost 85% of all technological and scientific information in the world is in English (Ammon 2001), to which one must add a pressure to produce work in English and to publish internationally that has increased considerably in recent years, because "publications in major international medical journals are considered more valuable" (Treanor, 1999). It follows, therefore, that it is necessary for members of the medical community and researchers to be able to search for scientific literature in English and to express themselves in this language if they want to be totally accepted by the international academic community. Indeed, in the academic world, it is said: 'publish in English or perish' (Bakewell 1992; Viereck 1996 in Keresztes 2009:60).

> The fact that English now occupies an overwhelmingly predominant role in the international world of scholarship and research [...] entails that the coming generation of the world's researchers and scholars need […] to have more than adequate professional skill in the English language if that generation is to make its way without linguistic disadvantage in its chosen world. (Swales 1990:10).

The percentage representing the dominance of English in the written record is very high, i.e., 89% of all scientific and technological articles (80% of databases and 62% of CD ROMs are in English), therefore, knowing how to write and publish in English is the basis of a successful career for researchers (Keresztes 2009:59). However, what is important, is the core of scientific publishing worldwide, consisting of some 4,000 or 5,000 English-language journals, the first step for almost all researchers and scholars to access scientific information, which is increasingly being shared via the Internet.

2.4 CONSEQUENCES OF GLOBAL DOMAIN OF MELF

> English can be seen as a neutral Lingua Franca, or as a powerful and dominant language (Tardy 2004 in Keresztes 2009:61).

Swales (1997:374) even compares it to a Tyrannosaurus rex, "a powerful carnivore that devours the other inhabitants of academic language pastures", furthermore he has labelled English as a tyrannosaura language, which makes all other academic languages 'endangered' or lead them to the marginalisation (Phillipson 2008 in Keresztes 2009:60). The increasing use of English as a Lingua Franca and its dominance in the field of medicine could, in the worst-case scenario, even increase the gap between doctors, other healthcare professionals and patients, preventing them from speaking about their subject in their mother tongue (Csedő 2005 in Keresztes 2009:60). This would in fact lead to a breakdown in communication between experts and the general public, so doctors working in primary health care definitely need medical literature available in their mother tongue (Fehér 1997). This is generally an imperceptible, gradual change with long-term effects; therefore, all medical professionals must necessarily learn English if they want to be informed about the latest developments in their field (Alcaraz and Navarro 2006).

Today, the dominance achieved by the English language has led to English-speaking countries forming a virtual cartel on scientific information (Nylenna 1994 in Keresztes 2009:61). Scientific manuscripts submitted in a language other than English are commonly regarded as inferior despite being of the same scientific quality (Vandenbroucke 1989) or even, publishing in the native language, if different form English, has become a handicap to the ambitions or future careers of the doctors (Bakewell 1992). There is much criticism of the increasing dominance of English at the expense of other languages. Indeed, it is believed that this causes a division of people, those who are more educated, as they used English in academic education, and those who are less educated (Keresztes 2009:62).

The predisposition to use English as the only Lingua Franca leads to the inclusion of Anglicism in any everyday conversation between non-English speaking professionals. These terms in English are present lexically, semantically but also syntactically. Moreover, this phenomenon leads to new patterns in the first

language of the professionals, and also to orthographical changes. Medical language is also characterised by the innovative use of acronyms, which are given in English and not in the different national languages (Keresztes 2003; Taavitsainen 2006 in Keresztes 2009:61). However, Latin, which was the Lingua Franca of medicine before English, has retained an important position in communication between doctors and in written documents, in fact, diagnoses and technical anatomical terms are still given in Latin (Keresztes 2009:61). Note also, however, the other side of the coin with regard to the globalisation phenomenon and the authority that the English language has acquired, becoming a global language for communication, namely people's desire to preserve national identity. This has prompted researchers and scholars, even in the field of medicine, to continue to write in their mother tongue, thus making their thoughts comprehensible even to a non-academic audience that does not make extensive use of the English language, which would otherwise remain alien to medical information. For example. As Davis (1995, 2006) states, in some countries (such as the UK), policies have been instituted on the use of language and interactions, for example in elderly care, even though this awareness is not widespread, so as not to linguistically debilitate patients (Ramanathan 2009).

According to some authors (Navarro, 2001; Fortanet, 2002; Crystal, 1997), this international scenario of the dominance of one language (English) and leads to a result such as the discrimination of other languages, and consequently the acceptance of a less than primary position in world science (Revista Alicantina de Estudio Ingleses, 2009). Crystal (1997:12-13) also points out how the existence of an international language could cause not only the disappearance of minority languages, but also the laziness on the part of people to learn new languages, since the use of a global language would suffice to satisfy every communicative need. House (1999), on the other hand, also emphasises the advantages of ELF, namely that its use and spread internationally allows for functional variability and flexibility, making it the main and most useful means of communication for the various reasons and domains in which it is used.

2.5 TEACHING ENGLISH AS A LINGUA FRANCA IN MEDICAL SETTINGS

> Is the ability to develop targeted knowledge, skills and attitudes that lead to visible behaviour and communication that are both effective and appropriate in intercultural interactions (Deardorff, 2006:258)

As Medical English as a Lingua Franca is a very recent and emerging field of study, for which further studies and research are needed, the teaching of this type of language also does not yet follow certain guidelines. A strategic project in cooperation with Erasmus+, "CLIL in Medical Education: Reaching for Tools to Teach Effectively in English in a Multicultural and Multilingual Learning Space" (CLILMED), attempted to identify what professional communication skills and behavioural attitudes medical students need and how they should be presented and intentionally integrated into teaching and learning in order to avoid any linguistic misunderstandings in their future careers.

Today, it is important that teaching offers flexibility in the language of instruction. According to Doiz, Lasagabaster and Sierra (2014), educators should move away from an obsession with “correctness” (Canagarajah, 2008:223) and instead move towards teaching that guides the use of language appropriately according to the particular context. Also, according to Björkman (2011), in ELF interactions effective communication is much more important than rigour and accuracy during interactions. And again "the ability to accommodate interlocutors with languages other than one's own is a much more important skill than the ability to imitate the English of a native speaker" as stated by Jenkins (2007:238). It emerges, therefore, that effective communication, even if not correct and accurate according to Standard English norms, between health professional and patient is responsible for patient satisfaction, adherence to care and treatment and consequently subsequent health outcomes (Betancourt, 2003; CLIL Journal of Innovation and Research in Plurilingual and Pluricultural Education, p.8).

In teaching medicine and health care in ELF contexts, in fact, the aim is to impart a broader knowledge of language skills, as well as knowledge and appreciation of different value systems (Corbett 2011:314-15) such as: awareness of one's own and other cultures, sociolinguistic awareness, as well as an

understanding of health issues in multilingual and pluricultural environments; key skills for effective intercultural communication in laboratory or clinical settings such as listening, observation, interpretation, evaluation, analysis, but also adaptability and flexibility; attitudes that include respect, openness, curiosity and empathy (Deardorff, 2006 in CLIL Journal of Innovation and Research in Plurilingual and Pluricultural Education, 2022:10). In order to succeed in conveying all this to students who will face a multilingual and multicultural dimension, always in close contact with people and in situations where they may cause serious health and care risks, it is necessary for teachers to play their role in the most transformative and innovative way ever by placing the learner and their needs for learning or practice at the centre, engaging them and leading them to exercise their communication skills and intercultural competence (Båge et al. 2020; Stains et al. 2018 in CLIL Journal of Innovation and Research in Plurilingual and Pluricultural Education 2022:12).

As the aim being considered here is to prepare students for effective communication in high-risk MELF contexts, a less passive approach is required (Medical English as a Lingua Franca, Tweedie & Johnson 2022 chapter 6.5.1) that includes, first and foremost, the teaching of listening skills that aim at comprehension of a wide variety of English and not only that of a 'standard' accent (Tweedie & Johnson 2018: 21), but also important is the teaching of specific vocabulary and strategies to prevent or avoid misunderstandings and consequently incorrect medical outcomes. Regarding the approach for teaching listening, in this area, it must move from being a static and receptive activity to being much more interactive (Tweedie & Johnson 2018:22) including:

- Intensive Listening, which focuses on understanding micro-elements of the utterance at phonological, lexical and syntactic levels.

- Selective listening, or 'Purposeful listening' (Morley 1972, 1980), which is important to train medical/nursing students' aural skills in reference to measurements, numbers, dosage quantities, abbreviations. Fundamental activity to avoid "wrong patients, wrong diagnoses, wrong dosages, wrong timing" (Hudson & Guchelaar 2003:1010).

- Interactive listening involving collaborative conversation (Tweedie & Johnson 2022 chapter 6.5.1)

- Extensive listening and autonomous listening, activities that aim to develop one's own awareness, knowledge, strategies and post-listening reflections. (Tweedie & Johnson 2022: 6.5.1). This is important for training students in patient-centred communication (Keifenheim et al. 2015), but also for patient safety itself (Tweedie & Johnson 2022:6.5.1).

Furthermore, through teaching based, for the most part, on simulations of 'real-world' situations (Tweedie & Johnson 2018:23), an attempt is made to implement a pedagogy for pronunciation by avoiding imitating standard English accents in order to facilitate comprehension in the multilingual contexts in which healthcare professionals will be working (Tweedie & Johnson 2018: 22); to use medical language corpora as much as possible to meet the need for accuracy and precision typical of the MELF (Tweedie & Johnson 2018:22); and finally, to have students develop strategies, to be used in patient communication, to avoid any kind of potential misunderstanding. These preventive strategies include repetition, speech reformulation (2022: 4.2.2), spelling (2022: 4.2.3), playback and non-verbal language (2022: 4.2.5), which not only "show interpersonal involvement in discourse and help to maintain and/or improve meaning-making" (Capuzzo, 2015:50), but also ensure effective and successful communication with the patient, indicate active participation on the part of the medical staff, and also understanding, acceptance, empathy and a positive environment for interaction.

Conclusion

Studies, although still limited given the emerging nature of this field of research, show that communication in the medical field requires the use of specific terminology, acronyms and stereotypical discourse structures for both practice and the computerised collection and storage of patient data required by international health organisations. This allows ELF users in the medical field to make use of language with a certain regulation and codification, which is opposed to the typical meaning of ELF characterised by variety, freedom in the use of language, and above

all of being dealt with in real time, without any retrospective preparation, as is the case in other ELF contexts.

Hence, it can be said that Medical English as a Lingua Franca (MELF) represents an emerging domain characterised in its use, against all expectations, by elements that are not typical of most contexts in which ELF is used. By this we mean pre-established language structures that are important for practice but which, while not contradictory, coexist with innovative or creative forms. Precisely because of this emergent nature, further studies and developments in its analysis will be necessary for a greater understanding of ELF, which would naturally lead to an improvement in health communication and consequently in the delivery of health services in the context of a multilingual society, as well. The social situations in which MELF interactions take place, such as medical consultations, exert a significant influence on language forms during communication.

I have mentioned that MELF users make effective use of a variety of multimodal resources for health communication, in innovative ways and often adapting between different languages. Furthermore, it has been seen that in MELF contexts certain language features are used against all expectations when referring to the medical/health field in which doctor-patient interactions take place, e.g. excessive use of specific language is not helpful for patients, doctors are used to direct communication by taking authoritative positions, and most importantly the high potential for errors with life-threatening consequences (Tweedie & Johnson 2022: 6.6) due to incorrect and effective communication. In this regard, scholars, and teachers of English for specific purposes, and in this case ELF teachers in the medical field, have attempted to identify interactive, rather than passive, pedagogical approaches dedicated to the practice of listening, non-standard pronunciation, and how to develop preventive strategies to be used with patients in order to avoid misunderstandings and potentially serious errors for people's health.

CHAPTER THREE

ANALISIS OF THE USE OF ELF IN MEDICAL SETTING: A CASE STUDY OF THE UNIVERSITY OF PADUA

INTRODUCTION

The aim of this chapter is to analyse the answers I received from the questionnaire I created in order to better understand how English as a Lingua Franca is used in the medical field, especially in the practice of this discipline. In order to do so, I will refer to the results of the survey I personally submitted to the students of the "Medicine and Surgery", a course delivered in English by the University of Padua, which investigates their opinions and information about the skills acquired during their years of study or internship. All survey questions and their answers can be found in the Appendix.

This study investigated one question in particular, that is: in MELF interactions to what extent do the four main "language skills" of English, which are listening, speaking, reading and writing, but also, in this context, their knowledge of grammar norms and vocabulary, impact on their future employment, according to the students of Medicine and Surgery in English at the university of Padua?

3. RESEARCH SETTING

This research study was finalised thanks to 75 students of the Medicine and Surgery course, which has English as its language of instruction, provided by the University of Padua. The body of students who volunteered to fill out the survey included people in an age range of 19 to 38 years old, with the majority being 20 (25.3%), 21 (26.7%) and 22 years old (21.3%), and 17% of whom are currently attending the first year of the course, 47.8% the second, 25.4% the third and 9.3% the fourth.

Among the initial questions, they were also asked why they had chosen to study Medicine in English, and it is interesting to observe some of their answers, such as: "I want to work abroad", or similar "To study abroad and to have more work opportunities in the future"; "Because I believe that nowadays a degree in English will allow me to have more career related opportunities compared to a same

level degree in Italian or other language" or similar "Because I wanted to keep myself open to more future possibilities" as they reflect why English language has become the International Lingua Franca, useful and effective for any purpose, be it academic, work or communication. They also reflect the fact that the English language is considered to be the key to "open many doors", in other words, to grant many opportunities at an international level, thus fostering continuous development, whether personal, of researchers or doctors, but also of the science of medicine (Csilla 2009: 56). Two other students, however, gave the following answers: "To have quick access to medical literature and to be able to update in real time" and "Better curriculum with respect to the traditional course", which refer, as already explained in the previous chapter, to the dominance that the English language has reached nowadays, so much so that its knowledge and use in the scientific field is considered necessary, if researchers or doctors “want to be informed about the latest developments in their field” (Alcaraz and Navarro 2006) “or if they want to be considered as "more educated, as they used English in academic situation” (Csilla 2009:62).

Another important thing to note, however, is the fact that their academic and working environment represents a multiple language scenario, as almost all of the survey participants have a language other than English as their mother tongue, e.g. more than half have Italian as their first language (52 out of 75), some are native speakers of Arabic, or Romanian or Serbian, or one student among them has Farsi (Persian) as their first language, another Tagalog (Filipino), or Turkish or Portuguese, while only 8 of them stated that their first language was English. However, despite the fact that 23% of the respondents stated that they have a C2 English level and 54.1% that they have a C1 English level, their multilingual scenario makes us realise that both among themselves and in the academic and work environment they all have to use English as their main means of communication, , thus reflecting a (M)ELF scenario.

3.1 RESULTS

The answers obtained from the previously developed survey will relate to the point of views of the students who volunteered to answer the questions. It is

important to note that answers were obtained from students who either have not yet had the opportunity to put their studies into practice because they are in the early years of their academic careers, or students who have had, for a limited period of time, the opportunity to practise using English as a Lingua Franca. In any case, there are students who have not yet gained that work experience that allows them to explain with certainty what linguistic features could influence patient care and safety.

The core questions of the questionnaire started by asking the participants whether their level of English, for their future career, had improved since they started their university career, and 74.3% of them gave positive answers while 25.7% gave negative answers. Of those who responded positively, almost half of the participants also stated that the main skills in which they had improved were Speaking first (Fig.4), while the lowest percentage and therefore the skill for which they felt they had not improved much was Listening. With regard to Speaking, as we shall also see later, this is a positive result, as it indirectly shows that the students are being taught in the right way how to approach the world of work and especially with other doctors or patients, since for many students and scholars alike, the ability to communicate in the right way in the medical and health care context, and especially in the ELF context, is a skill that encompasses many facets. It will be seen specifically below that in the MELF context, speaking is more than just communication aimed at comprehensibility on the part of the other interlocutor involved in the communication; it is "appropriateness or formality, which cannot be assessed on the basis of fixed conventions, or in other words 'norms', of a specific discursive community, but inevitably becomes relative to the given context of the communicative situation" (Bakó 2020:134).

On the other hand, with regard to the students' room for improvement in Listening, the result could be regarded as ‘negative’ in that only 10.9% of the students feel they have improved this language skill. Considering what Tweedie and Johnson state, in one of their studies of medical English as a lingua franca for nursing education (2018:2), namely “listening, and content-specific vocabulary instructions as critical components in the language curriculum of MELF contexts”, it can be deduced that this language skill, among the students of the medical and

surgical English course at the University of Padua, should be fostered to a greater extent. Further on, it will be seen how important listening skills are according to the students' opinions during MELF interactions, whether they occur between doctor-doctors or between patient-doctors.

The remaining two language skills of reading and writing are not given much consideration when it comes to MELF interactions or communication, but in this particular case, students feel they have made progress as their study and preparation through medical literature and materials presented in lectures are also in English, so inevitably these language skills have also developed more since they began their studies. In addition, the course itself trains students not only to work in multilingual contexts in close contact with patients, but also to make the best use of information tools, for their continuing education and possible research and further specialisation, so all these language skills mentioned above are important.

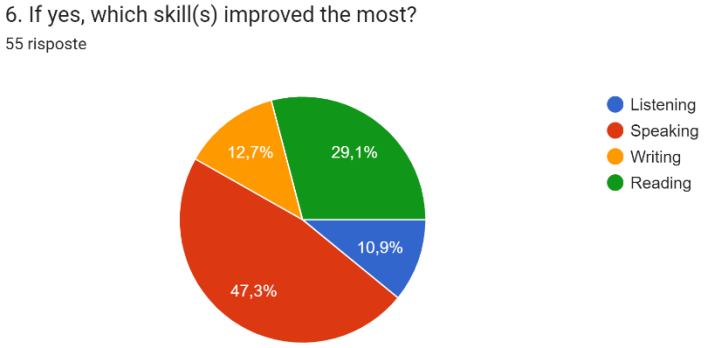


Figure 4

The students were then asked whether, in any way, language use in MELF contexts could influence patient safety and for 86.5% of them the answer was positive (Fig.5). This result confirms, in fact, what Tweedie and Johnson also drew from their studies, namely that the presence of language barriers or the absence of good language skills could lead to miscommunication or unintelligibility and consequently "inhibit access to care for patients, lower their adherence to treatments and decrease patient satisfaction", but in the worst case, could lead to a misdiagnosis of potentially dangerous problems (Tweedie and Johnson 2018:5).

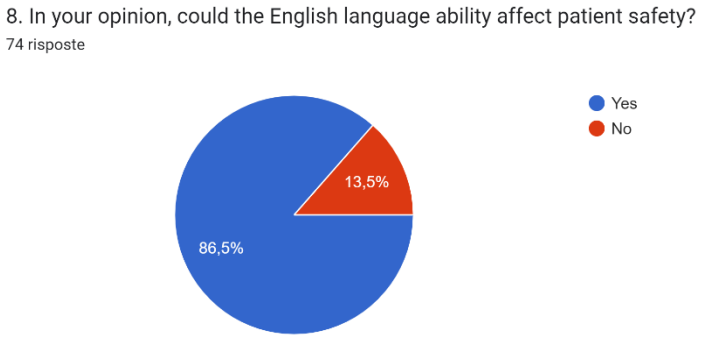


Figure 5

Specifically, as far as speaking communication skills are concerned, according to the participants on a scale from "not at all important" to "very important", more than 70% of them consider speaking skills (Fig. 9) to be very important; similarly, more than 60% of the students also consider correct terminology and specific vocabulary (Fig. 7) to be very important in medical interactions. A wide-ranging specialised knowledge that professionals have learnt to express through a vocabulary with specialised terms, for instance, to describe and discuss symptoms or diagnoses with specialist colleagues, to instruct medical personnel, or to compile charts and write medical reports, is of crucial importance in this context. Similarly, Tweedie and Johnson (2018) state that content-specific vocabulary and precise expressions are critical components to avoid hindering MELF communication. In this precise context, however, it is not only necessary to draw on this collection of knowledge while trying to communicate, rather one should "exploit this knowledge to achieve a particular communicative purpose" (Widdowson 1983: 34). More explicitly, in the case of physicians, it is not enough to have an extensive vocabulary containing various designations and a formality typical of a native speaker of the target language as this register is not universally understood when considering a background not shared by the parties. What is important is that they are actually able to shape their language use by drawing on these sources.

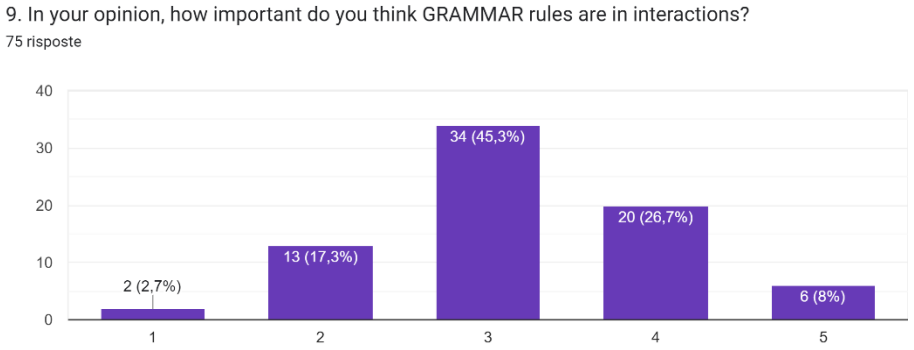


Figure 6

As far as the importance of grammar rules within MELF interactions is concerned, the students attributed them a "medium" importance: in fact we see that 45.3% of them do not consider them either not at all important or very important. This is a result that goes, in part, against what is claimed by scholars. As already made explicit in the previous chapter, MELF communication is not oriented towards correctness of the form of language, but rather towards mutual understanding; in fact, in international contexts, especially ELF contexts, appropriateness, that is, the level of correctness, cannot be assessed on the basis of fixed conventions, or in other words norms, of a specific discursive community, but inevitably becomes relative to the given context of the communicative situation (Bakò 2014:134). Also according to Tweedie and Johnson, his research study (2018) showed that grammar issues are not considered as language barriers that could compromise patient care and safety.

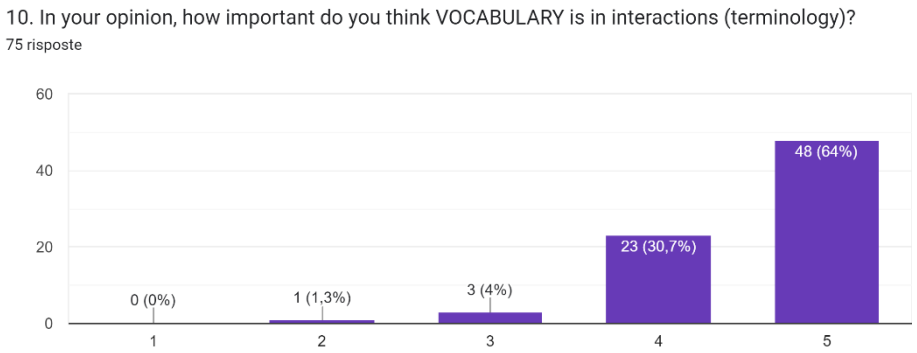


Figure 7

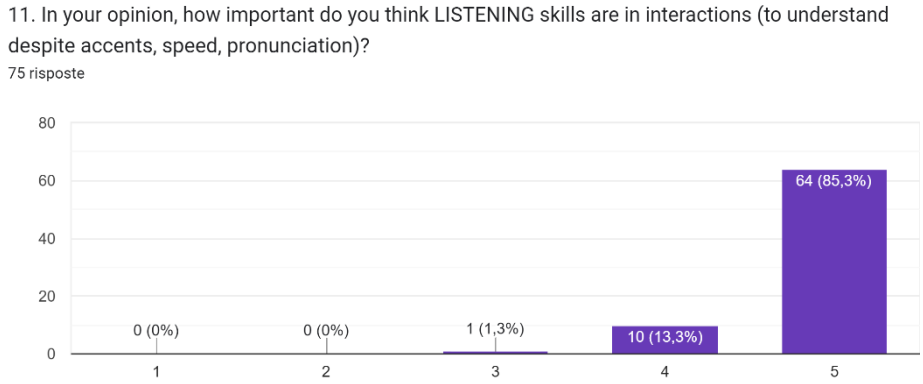


Figure 8

The answers obtained from the students concerning the importance of having good listening skills during medical practice in international settings confirm what was explained in the previous chapter. For as many as 85.3% of them, having good listening skills is very important in MELF interactions. In fact, according to scholars, this language skill is the first one that needs to be taught and practised by the students in order to prevent or avoid possible misunderstandings and consequently incorrect medical diagnoses. According to Tweedie and Johnson (2018:22), the best approach for effective teaching regarding the linguistic skill of listening is through non-passive, but active activities which are referred to as purposeful listening, intensive listening, interactive listening and extensive listening, as specified above. These are interactive activities that train students in exceptional precision for patient assessment and quality care, as well as facilitating comprehension in the multilingual contexts in which healthcare professionals will be working.

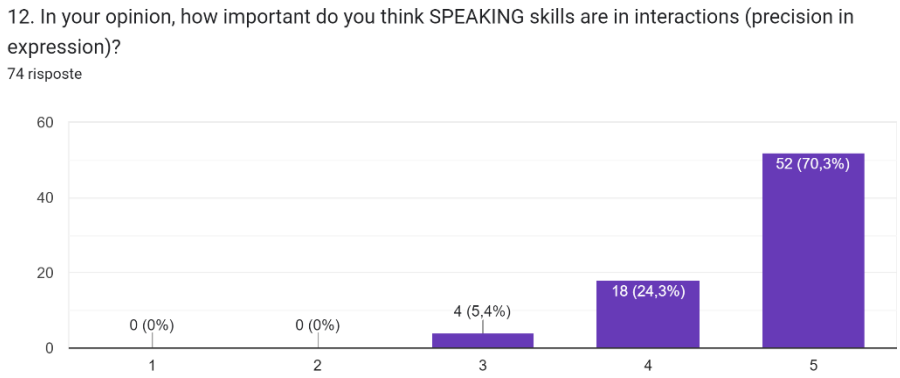


Figure 9

Previously, with respect to the language Speaking skills, the need for professionals or medical staff to adapt their language register and their use of language according to the cultural background of the patients or other professionals with whom they have to interact, while still conveying accurate and correct information, was made explicit. In order to achieve even more efficient and effective communication with non-native English-speaking patients or other non-native English-speaking colleagues or professionals, however, it is necessary to develop problem-solving skills through pragmatic strategies, such as repetition, speech reformulation, self-correction, error-repair, to circumnavigate misunderstandings (Chapter 2.5), where people's lives are often at stake.

It can also be seen how these pragmatic strategies lead to greater clarity and efficiency in communication between doctor and patient, through the following testimonies of some students who had the opportunity to put their theoretical knowledge into practice in a context where they did not share the same linguistic and cultural background:

"[…] the key to have a satisfactory conversation was to always explain myself in more than one way, by being open to repeat with different words the concepts if necessary and without being afraid to ask the patient to do the same for me. By doing that the conversation was smooth and, in some way, also friendly, a good way to establish a close relationship with the patient despite the different first languages we had".

"[…] I needed to be ready to change words, finding synonyms or equivalent expressions in order to make me being understood by her (I realized I was using English sentences that made sense with an Italian language mindset, but for a native English speaker they were not so understandable). So, I needed to change them, since such patient couldn't understand me otherwise. It's a totally different feeling when you're speaking a language, which is not your native one, with a person who can only understand that."

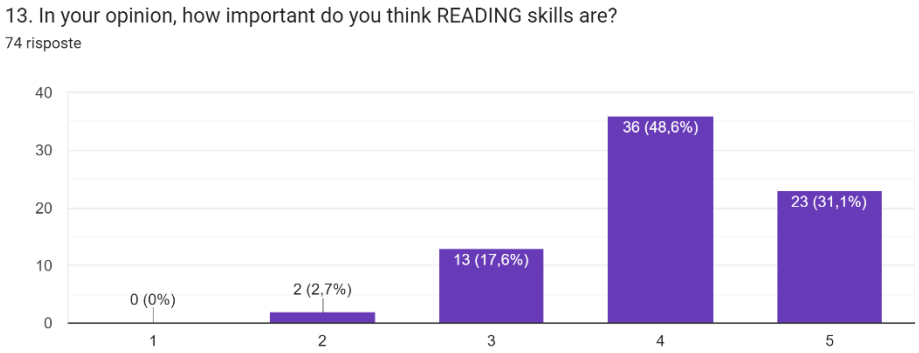


Figure 10

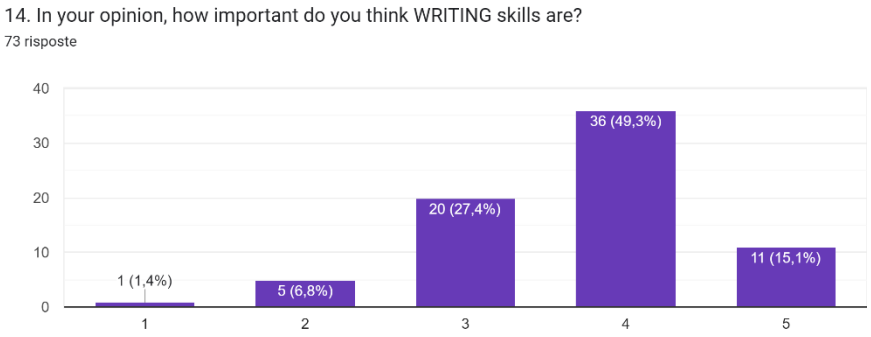


Figure 11

Subsequently, students were asked how important it was to have good reading (Fig. 10) and writing skills (Fig. 11) in a MELF context. Since these are communicative contexts that have to do with face-to-face interactions, little is said about the latter two language skills. Nevertheless, for almost 50% of the respondents, they are both very important skills, presumably for their academic learning, which also includes these activities. These are activities that, despite being

often neglected in MELF teaching, could influence students' clinical practices in the future. Indeed, the teaching of writing or reading to professionals and trainees is mainly done to improve the care that the physician is able to render to the patient's situation, e.g. by increasing attention, increasing accuracy and, furthermore, enabling empathy; and by providing the patient with the physician's knowledge, skills and care, shared through effective patient-clinician interaction (cognitive scientists and literature scholars teaching in clinical settings agree on this point) (Academic Medicine 2016).

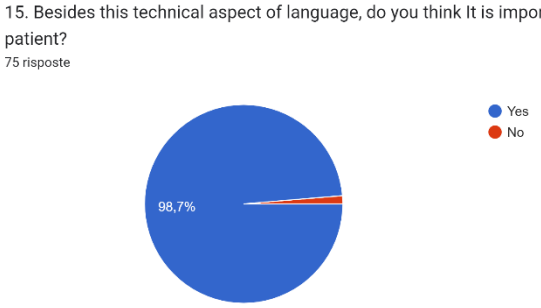


Figure 12

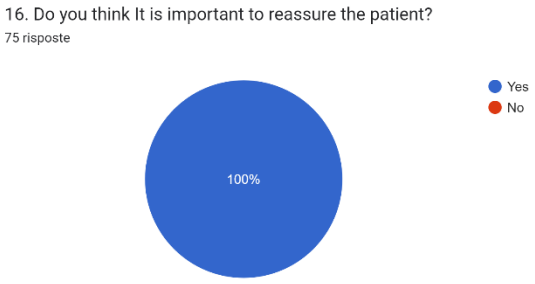


Figure 13

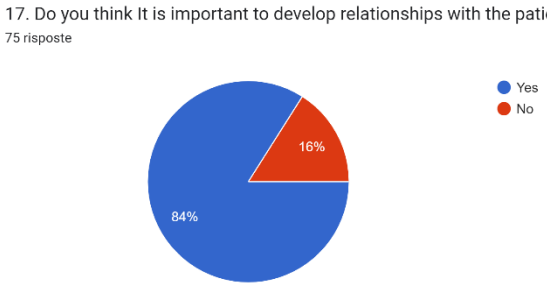


Figure 14

Finally, respondents were asked to give their opinion on an issue that goes beyond mere medical language skills in international contexts, namely the importance, in clinical/medical practice, of empathising with patients, or having a relationship with patients. Their answers show that for 98.7% of them it is important not only to be professional, precise and clear, but also to be empathic (Fig. 12); all students believe it is important, in fact, to be able to reassure patients (Fig. 13) and over 80% of them think it is important to develop a human relationship (Fig. 14). It is, however, interesting to note that one of the main concerns in MELF interactions is how to build rapport with patients, i.e. "a relationship characterised by agreement, mutual understanding or empathy that makes communication possible or easy" (Merriam-Webster Medical Dictionary: online). This interpersonal involvement, as well as professional involvement, can be developed through non-verbal communication, gestures, postures, eye-contact and tone of voice, thus enabling active participation on the part of the medical staff, and also understanding, acceptance, empathy and a positive environment for interaction (Chapter 2.5). This relationship, therefore, has a positive effect on patient satisfaction, adherence to treatment plans and thus on overall clinical outcomes (Fong Ha, Longnecker 2010: 38).

3.2 CONCLUSION

From the analysis of these answers, it can therefore be stated that communication in the medical field is a delicate issue for health care professionals, as it is necessary to pay attention to many features in order to guarantee the highest possible level of efficiency in a given communication situation. In such interaction, certain barriers can be encountered such as imprecision in language, different accents, incomprehensibility, but also the very limited time available especially in cases of emergency, dealing with delicate issues where many times negative information has to be given to the patient, or simply the patient feels helpless in the hands of the medical staff. If dealing with communication in the medical sphere is complicated even when sharing the same mother tongue, in the case of ELF communication the situation becomes even more complex since the mediating language between the health professional and the patient is English, and the shared

cultural background is limited. Indeed, here culturally and linguistically appropriate communicative competence is a crucial skill for health workers because it can literally save lives (Van de Poel 2013:vii). This competence, as seen, certainly becomes effective through the use of specific and formal terminology referring to medical terms and concepts, which is important as it can save time in healthcare situations where people's lives are often at stake.

Yet, medical interactions can be more effective, if doctors or healthcare professionals communicate with contextual and terminological awareness, in other words, by trying to understand the linguistic and cultural background of the patients in order to find common ground with respect to the means of communication to be used to ensure mutual understanding. They also need to adapt medical jargon with more commonly understood expressions. It is also important, in this medical ELF, to also develop problem-solving abilities and to establish a relationship with patients through, for example, pragmatic strategies or non-verbal language, which allow for better understanding, greater empathy towards the patient and a positive environment for interaction so that misunderstandings with patients or other professionals are prevented and avoided. In this way, patients may have greater trust in professionals and thus greater adherence to treatment, but it also means that erroneous medical results/diagnoses can be avoided.

Therefore, it is important that the pedagogical approach of this course should focus on developing contextual awareness and enabling students to develop a linguistic ability to exploit all theoretical knowledge and sources that can shape their use of language in order to improve the effectiveness of their communication with ELF patients.

CONCLUSION

In conclusion, despite the fact that the MELF phenomenon is still an emerging field of study and requires further investigation, it can be deduced from the studies done so far that the use of English as a Lingua Franca in the medical field is a delicate and complex issue. It has been proven that in this field, in which the shared linguistic and cultural background is very limited, contrary to the fact that it is generally characterised by a certain freedom of speech due to the lack of prior preparation as it is solely oriented towards mutual understanding, it is crucial for scholars and practitioners to communicate with a certain terminological precision, medical jargon and conventional discourse structures required by international health bodies. At the same time, however, this linguistic and cultural inequality can hinder understanding between the various interlocutors, be they other professionals or patients; it is therefore necessary to find an expedient that can prevent or eliminate any likelihood of miscommunication. This can be achieved by trying to communicate with a certain awareness of the interlocutors' knowledge base, linguistic ability and cultural background, then adapting medical jargon with more commonly understandable expressions, developing problem-solving skills when linguistic barriers hinder mutual understanding through pragmatic strategies such as repetition, rephrasing part or all of the expressed information, possibly spelling precise terms.

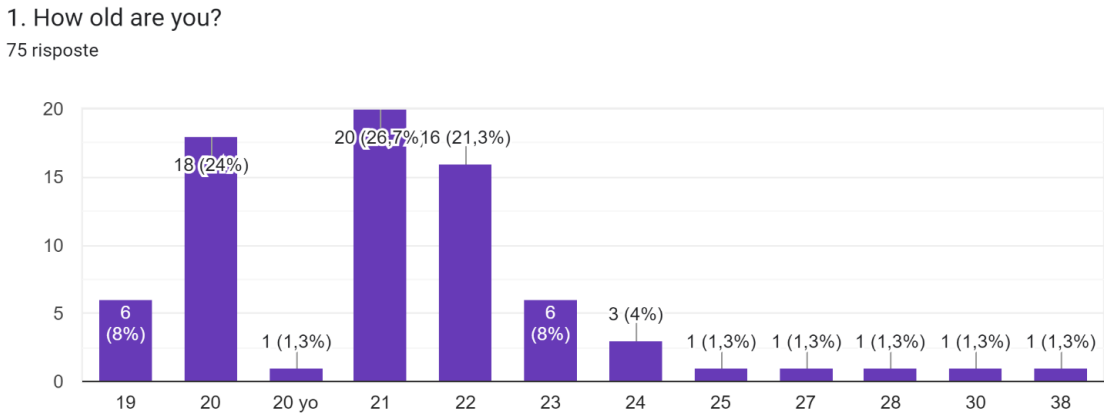
Finally, it has been noted that greater communicative efficiency results from a positive interactional environment that can be achieved through curiosity, openness and empathy on the part of professionals in the case of patient interactions. In order to do this, it is important that ELF teachers for specific purposes, and in this case in the medical field, do not use passive pedagogical approaches, but rather interactive ones that simulate real-life situations directed towards listening to non-native-accented English speakers and towards the development of preventive pragmatic strategies to avoid misunderstandings or errors in communication, as in this specific case the latter can literally save lives.

APPENDIX

Hi everyone! My name is Martina Carraro and I am a student of Languages, Literature and Cultural mediation at the University of Padua. I am now writing my bachelor's dissertation on the use of English as a Lingua Franca in the field of Medicine. My aim is to observe how the English language as a Lingua Franca is used in the medical field, for this reason I ask you as English-medicine students, how you would use the English language in your future career.

In order to help me in my studies I would be grateful if you could fill in this short questionnaire. It is anonymous and it will take about 5 minutes to complete. It contains some general closed and half-closed questions. Please give your answers truthfully, in order to ensure the success of the investigation. Thank you for your time!

Before you start, bear in mind that, throughout the questionnaire, I refer to the use of English as a Lingua Franca, that is a language used as a means of communication between people who do not share the same mother tongue. Here, in particular, used in the field of medicine.

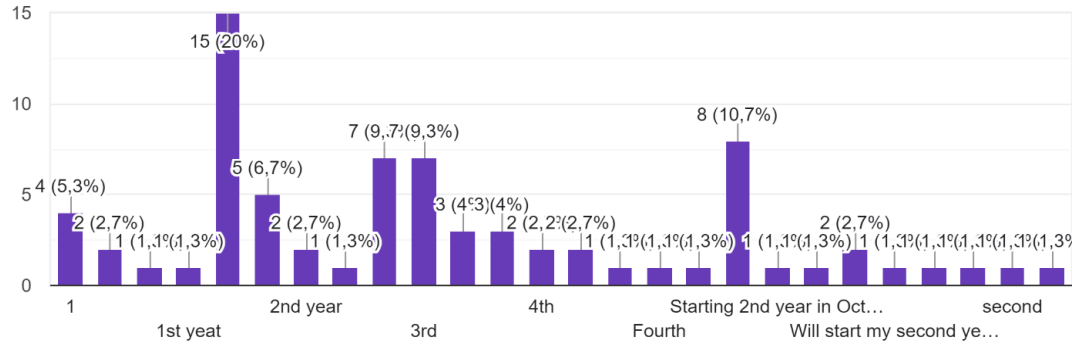


2. Which is/are your first language/s?

75 risposte

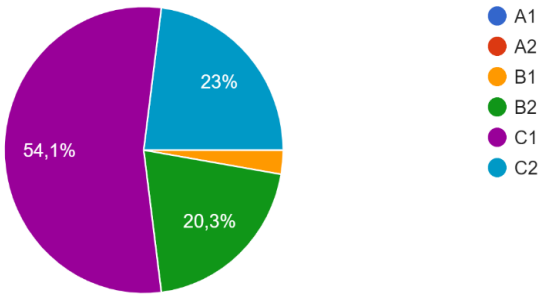
3. What year are you currently attending?

75 risposte



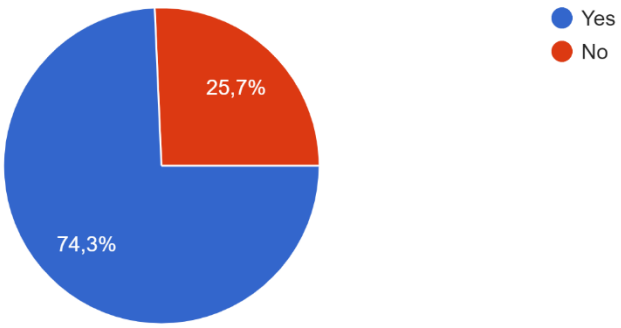
4. How would you rate your level of English? https://europa.eu/europass/system/fil...20-05/CEFR%20self-assessment%20grid%20IT.pdf

74 risposte



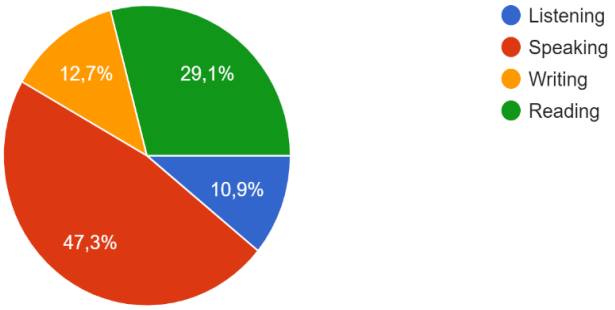
5. Has your level of English improved since you started studying Medicine in English?

74 risposte



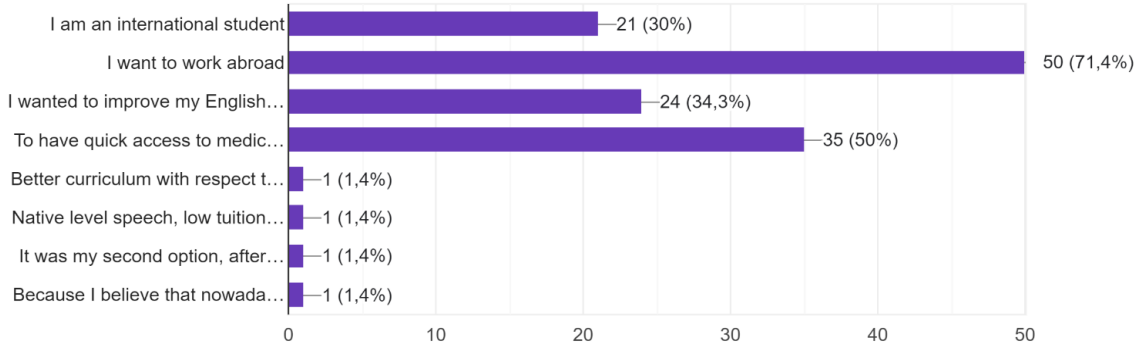
6. If yes, which skill(s) improved the most?

55 risposte



7. Why did you decide to study medicine in English?

70 risposte



If your answer was "Other"

(11 risposte)

- See above

- I spent a year abroad, and I wanted to keep studying and using English on a daily basis.

- Because I wanted to keep myself open to more future possibilities

- To study abroad and to have more work opportunities in the future

- I was able to enter a University in a city closer to my home

- It was my second option, after Medicine in Italian. Now, I'm so much grateful I happened to study in this course; I would choose it as my first choice.

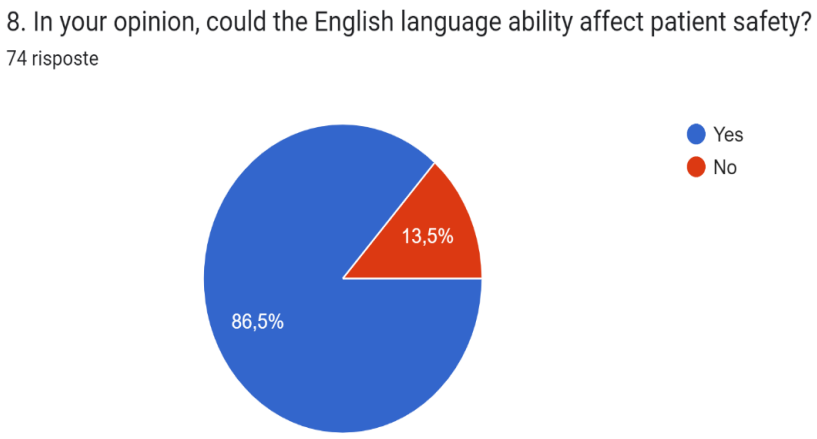
- I find it appealing

- Because I believe that nowadays a degree in English will allow me to have more career related opportunities compared to a same level degree in Italian or other language

- The course was expected to be more modernly structured and taught. Unfortunately it is not.

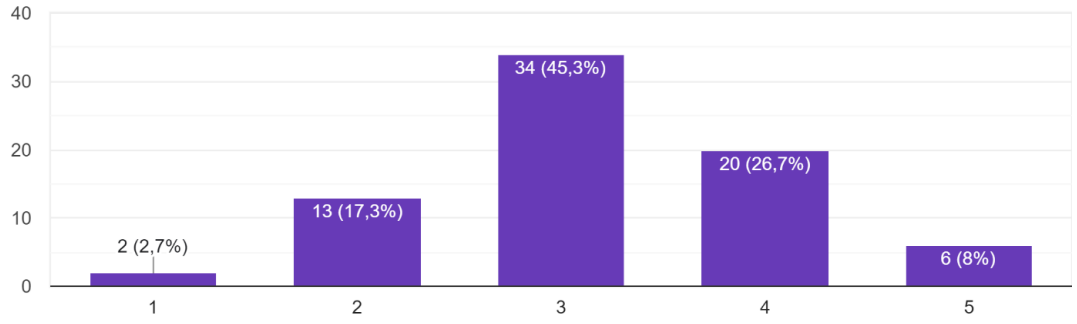
- To know people from abroad

- I wanted to study in Padua and entered in English before than Italian, so I chose it



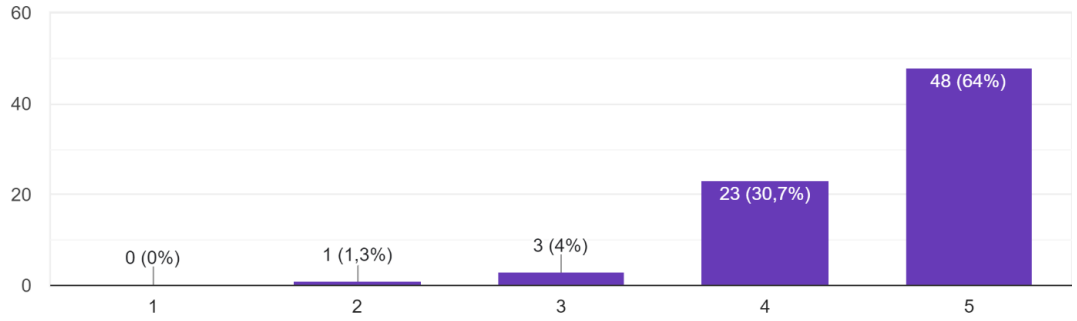
9. In your opinion, how important do you think GRAMMAR rules are in interactions?

75 risposte



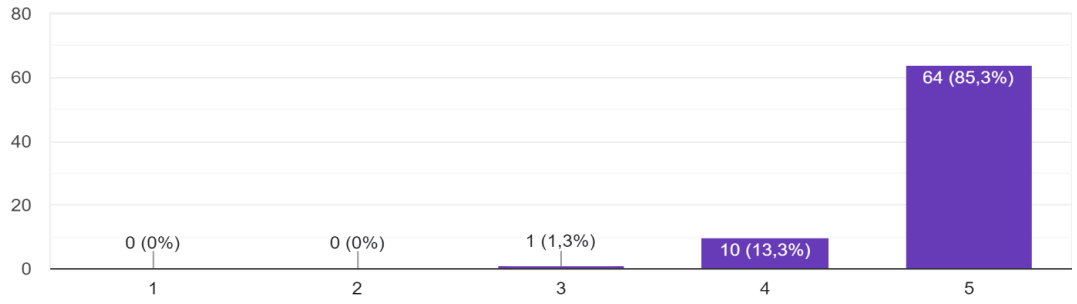
10. In your opinion, how important do you think VOCABULARY is in interactions (terminology)?

75 risposte



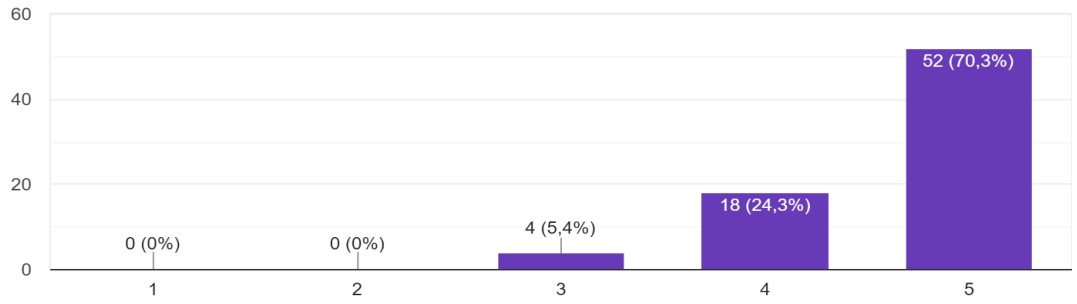
11. In your opinion, how important do you think LISTENING skills are in interactions (to understand despite accents, speed, pronunciation)?

75 risposte



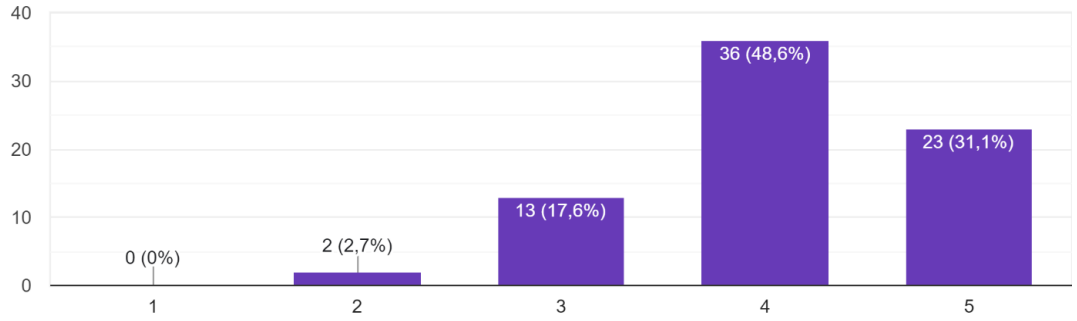
12. In your opinion, how important do you think SPEAKING skills are in interactions (precision in expression)?

74 risposte



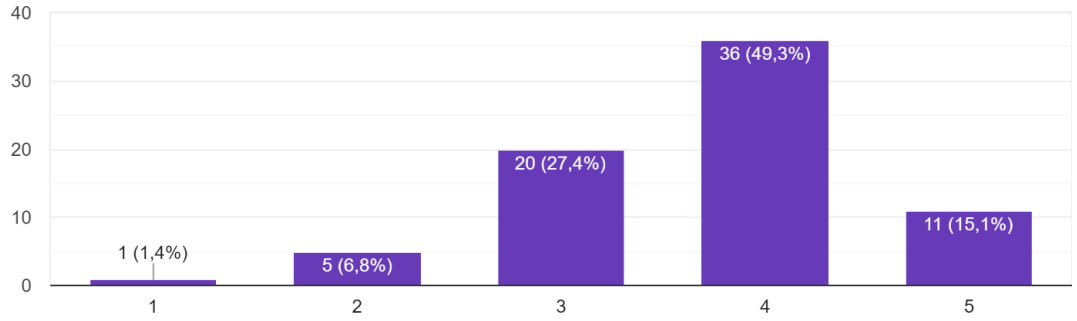
13. In your opinion, how important do you think READING skills are?

74 risposte



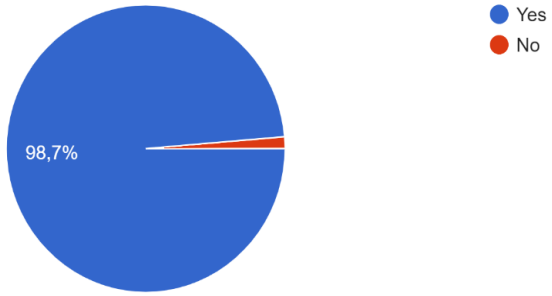
14. In your opinion, how important do you think WRITING skills are?

73 risposte



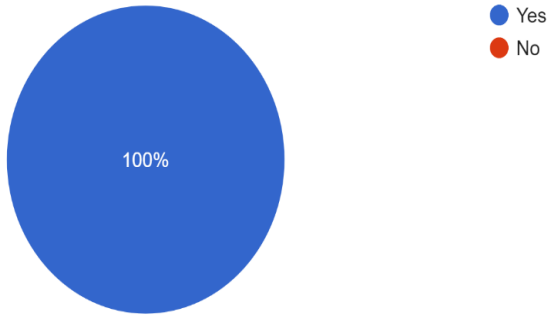
15. Besides this technical aspect of language, do you think It is important to empathise with the patient?

75 risposte



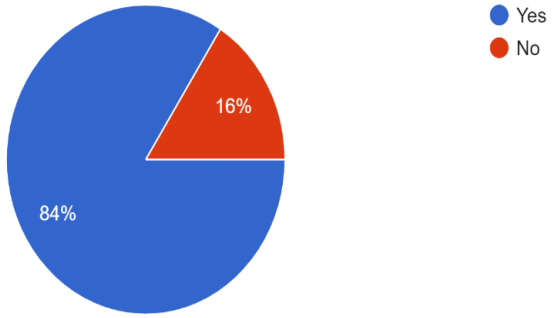
16. Do you think It is important to reassure the patient?

75 risposte



17. Do you think It is important to develop relationships with the patient?

75 risposte



18. Have you ever had an internship experience abroad or have you ever had to deal with situations where the only language for communicating with patients/experts was English? Tell me about your experience

(40 risposte)

- No

- no

- I am an emergency technician in the local EMS and have often encountered issues with language barrier

- I'm a volunteer in a point of first aid in Cavallino-Treporti where do we have to deal every day with patients from abroad so usually English is the only one language useful when we don't have the translator

- Yes. Working in my father's medical practice in the United States as a record clerk and general assistant I had frequent encounters with patients and doctors in English only.

- Prof. Novek, an American doctor now living and working here in Vicenza, assigned us a project: go visit a patient and try to collect data and medical history. The interview was of course in English, since all patients were from the US but living in Italy. The experience was great, very useful and enjoyable

- I had an internship in a biology lab in Padova in which I used English to communicate with foreign phd students and researchers.

- I come from Canada, most of my experiences have been using English as a lingua franca

- I haven’t but I hope to in the future

- I have never done an internship (with patient's interaction) either abroad or here in Italy so as of now I can't really answer this question, sorry.

- Yes. As an exchange student

- Not yet, but I am planning to get an internship experience in an anglo-saxon country.

- No, the only internship I had abroad was in Germany

- Yes, I had to talk with a patient whose mother tongue was english (american) and the key to have a satisfactory conversation was to always explain

myself in more than one way, by being open to repeat with different words the concepts if necessary and without being afraid to ask the patient to do the same for me. By doing that the conversation was smooth and in some way also friendly, a good way to establish a close relationship with the patient despite the different first languages we had.

- I did an internship in a hospital in the States, the patients only language for communication was English due to the environment. My communication and interactions with them were limited because I was shadowing the docs and nurses. I was more there to be friendly and chatty with the patients before the prep for surgery. In the rehab (drugs/alcohol) wing communications with patients were extremely restricted due to safety concerns both for us and patients. I talked a lot with lab technicians, docs and nurses. They were very easy to talk to and very welcoming, as most Americans are. We chatted mostly about the medical field, studying in the states, Italy and a little bit about the civil war of the 90s in Bosnia, where one of the docs did volunteer work as.

- During the first year of our course we could interact with a real patient of our professor as “doctor” in order to write his/her anamnesis. The interview to the patient was obviously in English. It’s very important having a connection with a patient even if it is only the first year.

- Actually I think it must be something that we star doing since the first year. Our course not only have more internships but it is also really focused on the ethics and the patient’s care.

- We had some lessons with teachers who only spoke english. Of course the comunication was limited to answering and asking questions

- For now, I never had such experiences

- No, not yet.

- I did not have any related experiences

- I worked for a couple of weeks in an Estonian clinic for English-speaking people. While my reading and writing skills were secondary to tasks at hand (mostly because I could take my time), the use of appropriate vocabulary, my speaking abilities, speed and pronunciation, and most of all my quick understanding of a

situation from a few words were vital in determining the patients' satisfaction with the service and their recovery.

- I don’t have enough experience for this to have happened, but I am certain that had I spent more time in the field, I would have had an example right now.

- Yes. I had this experience while doing a part time job as a salesman for Adidas. It was in Dubai and hence the customers are all from all over the world and English was the only way to communicate with everyone. English being a very influential and popularized language is spoken by a large majority of the people in the world and hence it is important even as doctors in order to ensure you can treat people from very nook and corner of the world.

- Yes, it was a phone call with a Native American patient. I sincerely struggled a bit to understand her, since her pronunciation was native; but in the end I did. Also, I needed to be ready to change words, finding synonyms or equivalent expressions in order to make me being understood by her (I realized I was using English sentences that made sense with an Italian language mindset, but for a native English speaker they were not so understandable. So I needed to change them, since such patient couldn't understand me otherwise. It's a totally different feeling when you're speaking a language, which is not your native one, with a person who can only understand that.).

- No, I haven't experienced that yet

- When I went to visit one of my friend in Erasmus I spoke with a Greek medical student about some medical topics and our future choices and the reasons behind them. Obviously we had to speak in English, otherwise we couldn’t understand each other.

- Yes, there was a patient from USA, it was kind of project of Approach To Patient subject. everything was good except after the interview I could not communicate her my feeling as I expected.

- Never happened

- Yes I was doing an internship at the Emergency Department of the Vicenza Hospital and I was shadowing an Italian doctor in the clinic for the white and green codes. One young patient from the Vicenza USA Army was admitted and since his nationality was American and couldn’t speak Italian, he could speak only English

which made it hard for the doctor to understand his symptoms and the clinical scenario. I had my chance to help both the patient and the doctor by mediating the conversation in the English language.

- Yes. I first arrived in Italy from Brazil when I was 16 years old so the only way I could communicate with my high school teachers and other students was in English. It was really hard because despite having English as my first language (I was born in the USA) most of my teachers could not speak English.

- I also had the opportunity to partecipate on the Erasmus+ project when I was in high school. I went to Germany for two weeks and there the experience was totally different, most teachers and students, but also people on the streets, were able to speak English at least on a level that allowed them to communicate.

- No I've never had it, I think this is a thing to improve in our course, we study in English but we never have the opportunity to practice it. I don't have a solid base of English from high school so I don't know if I will be able to work in an environment where the main language is English.

- I haven’t had any of such experience

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ABSTRACT

Lo scopo principale di questa tesi è quello di osservare le peculiarità della lingua inglese, nel caso specifico in cui quest'ultima venga utilizzata come Lingua Franca nell'ambito della medicina.

L'inglese detiene oggi lo status di lingua globale e, inoltre, il suo ruolo di Lingua Franca lo rende il mezzo di comunicazione più diffuso e utilizzato da persone che sentono il bisogno di comunicare tra loro, qualsiasi sia lo scopo e qualsiasi sia la loro lingua madre. Il fenomeno ELF è sorto come causa e conseguenza della globalizzazione, che ha permesso all'inglese di interessare diversi ambiti della vita quotidiana, sempre più multidirezionali e i cui confini, siano essi politici, economici, scientifici o socio-culturali, sono divenuti poco distinguibili, per tanto anche a livello linguistico, la distinzione tra parlanti nativi e parlanti non-nativi perde di significato. Si parla, oggi, diversamente da come di faceva in passato, solamente di utenti ELF. L'inglese come Lingua Franca, infatti, non viene visto come una questione in cui vengono seguite le norme di un particolare gruppo di anglofoni, ma una negoziazione reciproca che coinvolge adattamenti linguistici da parte di tutti e indirizzata unicamente alla mutua comprensione.

Alcune caratteristiche ricorrenti in questo particolare uso della lingua inglese le possiamo ritrovare ad esempio nell'omissione della -s alla terza persona singolare dei verbi al tempo presente, nell'uso incorretto di articoli determinativi o indeterminativi e di nomi numerabili o non-numerabili, oppure ancora per quanto riguarda la pronuncia, l'assenza della distinzione di suoni come /θ/ e /ð/. Queste caratteristiche, in questa circostanza, non vengono considerate come errori, al contrario di come lo sono in contesti linguistici nativi, ma come semplici sfumature della lingua che non interferiscono con l'intelligibilità nella comunicazione. Negli ultimi decenni, inoltre, l'inglese è diventato la lingua di comunicazione per eccellenza nel campo delle scienze della salute e della scienza medica, sostituendo, ad esempio, il francese o il tedesco e diventando così una sorta di seconda lingua comune per medici e ricercatori e, in generale, per tutti coloro che si occupano di discipline scientifiche. È, infatti, riscontrabile quasi completamente nella letteratura medica ed è considerato anche come principale lingua globale per la comunicazione

orale tra professionisti in occasione di convegni internazionali, quando coinvolgono la ricerca e il campo pratico per facilitare la comprensione tra persone la cui lingua madre è diversa dall'inglese. Anche se il MELF ha molto in comune con l'ELF, ne differisce per molti importanti aspetti, ovvero è più incline al processo di standardizzazione e codificazione, proprio a causa della natura delle interazioni mediche, le quali hanno l'obiettivo di trasmettere informazioni precise e accurate, in quanto le conseguenze di probabili incomprensioni o errori nella comunicazione potrebbero essere disastrose. Oltre alla necessità di padroneggiare un gergo molto tecnico caratterizzato ad esempio da termini tecnici, acronimi, e prefissi e suffissi che potrebbero modificare il significato delle singole parole, è molto importante anche il modo in cui avviene la comunicazione.

Poiché ci si trova in contesti multilinguistici e multiculturali, spesso sono presenti delle barriere linguistiche che mettono maggiormente a dura prova la comunicazione, le quali possono essere superate attraverso delle strategie pragmatiche linguistiche e non, che permettono di sviluppare una maggiore consapevolezza linguistica e talvolta culturale da parte dei medici o ricercatori. Ad esempio, quando ricorrono linguaggio impreciso e poco chiaro, accenti diversi, incomprensibilità, tempo molto limitato a disposizione nei casi di emergenza, situazioni delicate in cui molte volte si devono dare informazioni negative al paziente, strategie come la ripetizione di concetti o di espressioni poco chiare, lo spelling di termini difficilmente comprensibili, la riformulazione per intero o in parte di concetti attraverso termini più comunemente comprensibili evitando il gergo medico, la comprensione e l'empatia, oppure ancora linguaggio non verbale con dimostrazioni fisiche o contatto visivo, rendono la comunicazione più agevole e in ambienti comunicativi più positivi ed accoglienti.

Tutto ciò è stato, inoltre, confermato anche dalle opinioni e dalle conoscenze degli studenti del corso di "Medicine and Surgery" dell'Università di Padova, i quali sono stati sottoposti ad un precedente sondaggio per capire, effettivamente, l'uso dell'inglese come Lingua Franca nella loro futura carriera, e se una limitata abilità linguistica minacciasse la cura dei pazienti. Per tanto, risulta molto importante che l'approccio pedagogico in questo contesto sia indirizzato verso attività interattive che mettano a contatto gli studenti con situazioni reali, in grado

di far sviluppare in loro sia una abilità linguistica che si allontana da quella utilizzata in ambiti accademici, sia strategie che possano prevenire eventuali fraintendimenti durante un'interazione, dal momento in cui le vite delle persone sono dipendenti dall'abilità linguistica e in cui il margine di errore è molto limitato.

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