The importance of language assessment for bilingual staff in health services

ELISABETH GROVE, ANNA WHELAN, MAREE JOHNSON, CATHY NOBLE, CLAIR MATTHEWS

Introduction
Since its British colonial beginnings, this country has had a long and shameful history of ambivalence (at times open hostility) towards other races and their languages, accompanied by perennial uncertainty about what migrants of non-English speaking background have to offer this society. This can be seen in the recurring immigration debates, and, in particular, concern about whether a language background other than English should be regarded as an asset or a deficit, with the drain on resources that the latter term implies. For all that, at end of the twentieth century, we have an increasingly diverse population whose contributions must be recognised and whose needs must be met.

In the area of health, in particular, it is well known that the needs of various ethnic and language groups are not being adequately catered for. Hence, the initiatives taken by the Bilingual Health Project, part of which is reported in this paper. We begin by briefly discussing the need to draw on the language competence of bilingual health workers, consider the corresponding need for appropriate procedures to assess their language abilities, the benefits as well as the constraints on developing such procedures, and the main recommendations of the feasibility study undertaken to investigate these issues. At this stage, there is further work to be done and decisions still to be made, but for the time being, we report on the progress made to date.

The need for bilingual health staff
The problems caused by the unavailability of health staff able to communicate with non-English speaking patients have been substantially documented in recent decades. Patients of non-English speaking background (NESB) generally experience even greater communication problems than native speakers of English during health care interactions (Candlin et al 1974; D’Avanzo 1992; Elder 1990; Shaw 1997a; Shaw et al 1997b; Shuy 1981, 1983; West 1984). Whilst these problems may be due to a range of factors, it is generally agreed that language barriers are a major cause of miscommunication (McNamara 1990; Minas et al 1994; Pauwels 1991, 1995) and result in reduced health outcomes for patients. So there is increasing recognition that provision of appropriate bilingual support within the health care setting is crucial for optimal patient care.

Australia's cultural and linguistic diversity makes provision of this support particularly challenging. With the great concentration and diversity of different ethnic and language groups in major cities, interpreter and ethnic health services, although well-developed and widely used in hospitals, cannot satisfy the growing demands for their specialised skills, let alone provide the day-to-day social and health-related communication with NESB patients which would reduce their feelings of isolation in hospital. The need for staff with appropriate language and cultural competence is pressing. And there is a relatively untapped source of such skills in personnel already
employed within Australian health services, people who are ‘background speakers’ of a range of community languages and who regularly use their mother tongue in carrying out their normal interactions with patients.

However, to use the hitherto-neglected language skills of staff presents a number of difficulties, not least the problem of ascertaining the nature and extent of the language skills they possess. It cannot be assumed that all those who may be described as 'background speakers' of languages possess comparable levels of language ability or could perform the full range of their workplace tasks in the LOTE (Language Other Than English). Factors such as level of education in the LOTE, length of time in Australia and age at the time of immigration have a direct impact on the individual’s ability to use the LOTE for various communicative purposes (Elder, 1997). Such bilingual staff may, for instance, be recent immigrants trained professionally in their mother tongue, people who migrated as children and who have been educated in English, the children of migrants who speak the LOTE only at home and have been educated entirely in English, or, at the end of the spectrum, second- or third-generation children of migrants, who understand but speak the language very little, if at all. There are further differences too both within and among ethnic communities in the extent to which the mother tongue is maintained. With such variable degrees of proficiency and confidence in their LOTE among background speakers, it is obvious that bilingual and multilingual health workers will neither be equally endowed or equally willing to use their mother tongue in the workplace.

The Bilingual Health Project
Despite the complexity of multiple levels of communicative language ability and the difficulty of finding out what staff are really able to do with their LOTE, an innovative research programme, the Bilingual Health Project, has been initiated by researchers in the South Western Sydney Area Heath Service (SWSAHS)\(^1\), which serves one of the most ethnically and linguistically diverse areas in Australia, to do just this. With a commitment to ‘productive diversity’ (Cope and Kalantzis 1997) SWSAHS has sought to develop strategies for drawing on the linguistic and cultural skills of bilingual and multilingual staff employed in mainstream health services.

Involving major changes in policy and practice, the research program consists of a number of interdependent phases. Phase 1: the conduct of a language audit and examination of the experiences of bilingual and monolingual health service staff, forms the basis for the subsequent phases of the project; Phase 2: the development of innovative roles and service models for bilingual staff is nearing completion; Phase 3: the development of assessment tools for bilingual staff is currently underway; and Phase 4 will involve the development of policy for Area Health Services and the New South Wales Health Department on the use of bilingual mainstream staff in interactions with clients.

The first phase of the Bilingual Health Project has already been reported on in detail elsewhere by Johnson, Noble, Mathews and Aguilar (1997, 1998, 1999). However, it is relevant to note here that their research findings confirmed the perception that the needs of the ethnic health-consumer population are not matched by the availability of

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\(^1\) In the area covered by the South Western Sydney Area Health Service, of the total population of approximately 700,000, over 230,000 (36.5 per cent) speak a language other than English at home (ABS 1996).
appropriately qualified bilingual/multilingual staff, and that communication continues to be one of the major problems in the care of NESB patients. The 1996 language audit of all categories of SWSAHS employees (ward orderlies, doctors, nurses, allied health, administrative and catering staff) showed that 30 percent of "mainstream" staff were bilingual or multilingual. This included a range of perceived levels of proficiency and language use, from bilinguals who used their language at home, to second-generation migrants who mainly used English but were able to speak another language, to yet others who were multilingual (Johnson et al 1997, 1998, 1999).

This indicates the presence of a significant resource of language and cultural skills among hospital employees, which could be more positively used to the benefit of patient care. Apart from the boon to patients of being able to communicate in their own language, the reduced anxiety and greater likelihood of their understanding and being understood, the health system would undoubtedly benefit from the increased efficiency of enabling the patient to be cared for directly by a staff member communicating in the LOTE, without need for an intermediary. This could open the way for the implementation of a new model of health care much better suited to this country’s multicultural community than the current monolingual one, which is a hangover from our colonial past. These are among the possibilities currently being explored in the Bilingual Health Project.

**Why language assessment procedures are needed**

However, the situation is far from simple. The language audit which documented these under-utilised resources, also uncovered complications and problems in the present ad hoc and often inappropriate use of bilingual staff. A substantial proportion of the bilingual staff who participated in the 1996 survey (25%) admitted to unwillingness to disclose their LOTE background in the workplace, a number for fear that they would be expected to perform tasks for which their language skills were inadequate, or for which their work role was not suited. Some recalled alarming episodes in which they had been coerced by a superior into using their language for purposes which they considered compromising, and which entailed risk to patient and staff member alike. Yet others expressed concern at being over-used for their language skills, or attracting undue dependency from patients, or being regarded differently by other members of the work team (Johnson et al. 1997, 1998, 1999).

Clearly, possessing non-standard additional language abilities is not always perceived as an advantage. Coercion and/or inappropriate use of the LOTE have serious implications - ethical, legal and industrial – for all concerned – not least for the health service whose responsibility it is to ensure the quality of patient care and the working conditions of staff. It is therefore all the more incumbent on those seeking to utilise the linguistic and cultural assets of the workforce, to ensure that suitable safeguards are in place. If new models of health care are to be developed to incorporate the language and cultural skills of staff, it is obvious that possession of these skills should not be taken for granted. And if staff are to feel encouraged to use their linguistic abilities in the workplace, their skills need to be properly acknowledged and valued by the health service. At the same time, however, controls are essential: to protect staff from coercion to use their language skills inappropriately, to protect patients from staff who are not linguistically competent, and the health service from undesirable medico-legal problems. To determine whether staff have the competence to use their LOTE skills to perform the full range of their normal duties, or can operate in the LOTE only for

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more limited purposes, necessitates the use of formal assessment procedures. Currently, there is no accepted method for assessing the proficiency of bilingual health workers.

In the interest of developing suitable assessment procedures, the SWSAHS, together with the South Eastern Sydney Area Health Service (SESHAS) approached the Language Testing Research Centre (LTRC) at the University of Melbourne, which has expertise in designing health-related tests (the Occupational English Test (OET), in particular) and specific-purpose tests of LOTE proficiency. The study investigating the feasibility of developing test prototypes (Grove and Brown 1999) has been completed and work is now underway on test development.

**The bilingual health communication model**

In order to develop a test of language proficiency which can lay claim to validity and reliability, we have to be clear about the purpose of the test and precisely what needs to be tested. And this always depends on having in mind an appropriate model, or construct, whether explicit or implied, of language and its use. In the current project, the original researchers made considerable progress towards developing such a model, based on their investigation of the use made of their LOTEs by the health staff surveyed. This model, which they have called the Bilingual Health Communication Model, presents a continuum of language use, ranging from ‘simple’ to ‘complex’, in relation to the frequency with which staff routinely perform their work tasks in the LOTE and the implied linguistic complexity of the tasks. This model of bilingual language use forms the basic framework for the proposed test development. (See Johnson et al 1999 for a detailed description of the model and the process by which it was developed.)

To elaborate the main features of the model a little more for the purposes of this paper - in the language audit, staff were identified as belonging to three main groups according to their own perceived fluency in the LOTE, along a continuum of proficiency:

1. No fluency but cultural awareness and understanding.
2. Social fluency or language fluency in the home situation.
3. Sophisticated fluency (able to articulate and negotiate complex interactions across social and professional domains).

The project team also identified a range of communication situations in which staff used their LOTEs to communicate with patients. The context-of-use continuum distinguished the range of contexts into two broad categories, involving ‘simple’ and ‘complex’ language. As indicated in the following table, the majority of bilingual health workers use their language skills within the area of simple communication, with smaller numbers regarding themselves as complex verbalisers who also used their LOTE in the medico-legal domain.
Table 1. Situations of language use at work by bilingual staff (excluding Ethnic Health Staff/Interpreters) (adapted from Johnson et al 1997:33)

<table>
<thead>
<tr>
<th>Simple language</th>
<th>% response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple language (basic social exchanges)</td>
<td>17.6</td>
</tr>
<tr>
<td>Giving directions</td>
<td>13.1</td>
</tr>
<tr>
<td>Registering/booking</td>
<td>4.0</td>
</tr>
<tr>
<td>When patients are upset</td>
<td>9.1</td>
</tr>
<tr>
<td>Identification of problems and giving explanation</td>
<td>11.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complex health language</th>
<th>% response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking medical history/assessing medical condition</td>
<td>8.7</td>
</tr>
<tr>
<td>Explanation/consent for/ procedure</td>
<td>8.4</td>
</tr>
<tr>
<td>Consent for release of information</td>
<td>2.0</td>
</tr>
<tr>
<td>Written consent</td>
<td>1.5</td>
</tr>
<tr>
<td>Ongoing treatment</td>
<td>9.1</td>
</tr>
<tr>
<td>Education</td>
<td>8.3</td>
</tr>
<tr>
<td>Counselling/therapy</td>
<td>4.5</td>
</tr>
<tr>
<td>Other situations</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Although somewhat arbitrary, the dichotomy between simple and complex language use is a necessary distinction directly related to the dual purpose of the language assessment - to promote LOTE use for the purpose of daily social interaction with patients on the one hand, and to regulate and monitor its use for more specialised professional interaction on the other. Thus, the proposed assessment procedures are faced with the challenge of serving potentially conflicting requirements:

a) encouraging all staff to use their LOTEs appropriately for interactions with patients which may be limited to simple social routines or require command of more complex procedural and technical language, and

b) formally assessing the linguistic competence of professional staff (nurses, doctors and allied health staff, such as physiotherapists, dietitians and radiographers) in order to accredit them to use their LOTEs for more complex procedural or technical communication in their interactions with patients.

To satisfy both requirements is no small task. Nevertheless, the test developers have proposed assessment procedures which will incorporate these diverse purposes and at the same time cover the dimensions of fluency and contexts of LOTE use identified in the Bilingual Communication Model.

The proposed assessment procedures
With the additional requirement of designing an instrument flexible enough to accommodate the diverse groups and roles of hospital staff and, most importantly, one that will be easy and inexpensive to administer, the test developers have recommended a two-tier assessment model consisting of the following modules:

a) a self-assessment instrument (combined with a background questionnaire) to be completed by all bilingual hospital staff as a means of raising their awareness of their language skills and determining eligibility for further assessment, and

b) a phone-based interview of oral skills (both simple and complex), which staff meeting eligibility requirements will volunteer to undertake, and which will serve as a
means of formally accrediting their language skills for use in specified communicative domains.

The tests will initially be administered in Cantonese and Vietnamese, two of the major community languages represented in South East and South West Sydney, and pilot versions will be trialed early in 2000. It is also envisaged that the test will later be developed in other community languages, including Arabic, Mandarin and Spanish.

Conclusion
Considerable work is still to be done and there are further decisions to be made on how the results of the tests will be reported and acted upon by the Area Health Services. While the practical and policy implications of implementing such assessment procedures and developing appropriate accreditation mechanisms should not be underestimated, we are confident that the instruments developed and the information they elicit will be of significance to the health services of New South Wales, and also of interest to health systems around the country. This unique language assessment project not only has obvious benefits for the wider community, it also provides the opportunity for ground-breaking research into a range of issues pertaining to communication in multicultural work settings.

References


