



## THE IMPORTANCE OF KNOWING FOREIGN LANGUAGES IN MEDICINE

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**Abstract:** *Foreign-language competence is relevant to medicine in two distinct ways: it gives professionals access to research and international learning, and it can improve communication across language differences when clinical proficiency is sufficient. This article examines these roles through a focused narrative synthesis of empirical studies in medical education and language-concordant care, together with guidance from the World Health Organization (WHO) and the Agency for Healthcare Research and Quality (AHRQ). The evidence associates language-concordant care with better reported interactions and, in one large Canadian cohort, better in-hospital outcomes for some linguistic groups; such observational findings should not be read as proof that a language course alone changes clinical outcomes. The article proposes a task-based approach to teaching English for medical purposes that combines literature appraisal, clinical terminology, handover, plain-language explanation and interpreter-aware communication. Its central implication is that foreign-language learning should be taught as an assessed professional skill, with clear limits on independent clinical use.*

**Keywords:** *foreign languages; medical English; medical education; patient communication; language concordance; patient safety.*

### Introduction

Medical work crosses linguistic boundaries even when most local consultations take place in a national language. A clinician may need to read an international guideline, discuss a case with colleagues abroad, take part in training, or explain a procedure to a patient whose preferred language differs from that of the service. These tasks require different forms of language competence. Reading an



abstract, for example, does not establish the ability to obtain informed consent in the same language.

The WHO identifies communication breakdown among health workers and with patients as a patient-safety concern [1]. It also recommends removing language barriers through interpreting, translated information and culturally responsive services [2]. Consequently, the educational question is not simply whether medical learners should study a foreign language. It is what they should be able to do with that language, how their performance should be assessed, and when professional language assistance remains necessary.

## **Aim and method**

The aim is to analyse the professional value and practical limits of foreign-language knowledge in medicine and to derive an instructional model for English for medical purposes (EMP). This is a focused narrative review rather than a clinical trial or a systematic review. It draws on two observational studies of language concordance [3, 4], two studies of medical-student language learning [5, 6], and WHO/AHRQ guidance [1, 2, 7]. Sources were compared across patient care, scientific learning, teamwork and educational design; no local survey or intervention data are claimed.

## **Clinical communication and patient safety**

Language-concordant communication may make it easier to clarify symptoms, elicit preferences, discuss uncertainty and verify that instructions have been understood. In a U.S. survey of 8,638 adults with diabetes, Schenker and colleagues reported that patients with limited English proficiency whose physicians did not speak their language more often described suboptimal clinical interactions than English-proficient patients. Those with language-concordant physicians reported interactions closer to the English-proficient group [4]. These are patient-reported associations, subject to the limits of a cross-sectional design; they do not isolate language from every other feature of care.



A population-based retrospective cohort in Ontario examined 189,690 hospital admissions of frail home-care recipients. Among patients whose primary language was neither English nor French, those receiving mostly language-concordant physician care had lower adjusted odds of recorded in-hospital adverse events (OR 0.25; 95% CI 0.15–0.43) and in-hospital death (OR 0.44; 95% CI 0.29–0.66) than those receiving language-discordant care [3]. The authors found no significant difference in postdischarge outcomes. The setting, patient population and observational design restrict generalization; nevertheless, the study shows why linguistic access belongs in quality-of-care discussions.

Foreign-language learning has a limit that is especially important in clinical care. A doctor who can read English articles may still mishear a medicine name, misunderstand a patient's account, or lack vocabulary for discussing risks and consent. AHRQ warns against “getting by” with basic or intermediate language skills, and recommends qualified interpretation when communication is insufficient [7]. The practical standard is therefore role-specific competence: use the language independently for a clinical task only when proficiency has been assessed at the level that task requires. When it has not, arrange a qualified interpreter and document the patient's preferred language.

### **Scientific access and professional learning**

Foreign languages also support the steps that precede patient care. English proficiency can expand access to articles, international courses, conference discussion and collaboration. Yet access to a paper is not the same as being able to appraise it. Learners need to distinguish a study question from its conclusion, identify population and methods, interpret confidence intervals, and recognise when findings may not transfer to their own clinical context.

In six focus groups involving 24 medical students in an international programme, Chan, Mamat and Nadarajah found that students perceived English as relevant to training, research and future practice. Their findings also indicated that admission-level language requirements did not remove the need for opportunities to



practise context-specific communication [5]. This qualitative study reports student perspectives; it does not measure clinical improvement. Its educational value lies in showing why a general English course and a professional communication course should be linked.

International teamwork introduces further tasks: concise case presentation, accurate handover, clarification of uncertainty and careful questions when a term is unfamiliar. A short, standardised handover can be practised in language lessons; the clinical content should be checked by subject specialists so that linguistic fluency never masks an inaccurate medical statement.

A task-based analysis of professional language needs

Table 1 separates the settings in which language knowledge has value. It also shows why each setting requires a different assessment task. The suggested exercises are teaching examples, not a tested intervention.

Table 1. Medical language tasks, potential benefits and safeguards

| Setting            | Useful language task                                     | Potential value                            | Safeguard / assessment                                           |
|--------------------|----------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------|
| Research literacy  | Summarise the methods and limits of a clinical article.  | Access to evidence and critical appraisal. | Check the population, design, effect estimate and applicability. |
| Team communication | Present a case and hand over essential information.      | Clearer exchange in international teams.   | Assess accuracy and require a read-back for critical items.      |
| Patient encounter  | Ask and explain in the patient's preferred language.     | Trust, participation and understanding.    | Verify proficiency; use qualified interpreting if needed.        |
| Public health      | Adapt prevention material for another language audience. | More accessible health information.        | Review translation for meaning, literacy and cultural fit.       |



|                     |                                               |                                         |                                                       |
|---------------------|-----------------------------------------------|-----------------------------------------|-------------------------------------------------------|
| Professional growth | Discuss findings at a workshop or conference. | Participation in cross-border learning. | Separate fluent delivery from scientific correctness. |
|---------------------|-----------------------------------------------|-----------------------------------------|-------------------------------------------------------|

## Interpreting the evidence

The studies support a plausible relationship between communication and care quality, but they address different questions. Schenker et al. measured patients' reports in a diabetes population [4]; Seale et al. examined hospital outcomes in frail home-care recipients [3]. Neither study randomly assigned clinicians to language training. Observed benefits of concordant care may reflect other differences in clinicians, institutions or patient pathways. Thus a curriculum can reasonably target accurate communication, while any claim that the curriculum improves clinical outcomes would need a separate evaluation.

The educational literature also warns against using a single general-language score as a proxy for clinical performance. Chur-Hansen and colleagues studied 149 third-year medical students and found that poor spoken-language fluency, rather than language background or overall performance on their screening test, was associated with weaker medical communication under examination conditions [6]. The particular assessment and historical context matter; still, the finding strengthens the case for direct observation of spoken tasks rather than vocabulary tests alone.

These distinctions produce a practical hierarchy. Reading competence helps learners use scientific sources; professional speaking helps them collaborate; and clinically safe patient communication requires task-specific proficiency, confirmation of understanding and interpreter support when the exchange exceeds a clinician's language ability. A teacher can design language practice around these observable performances without claiming that every learner is ready to provide independent bilingual care.

## Teaching English for medical purposes

A useful EMP programme begins with the work learners actually need to perform. Figure 1 links language competence to three professional routes while



placing a clear clinical safeguard beneath patient communication. The figure is a conceptual synthesis of the cited evidence and guidance; it does not represent a measured causal pathway.

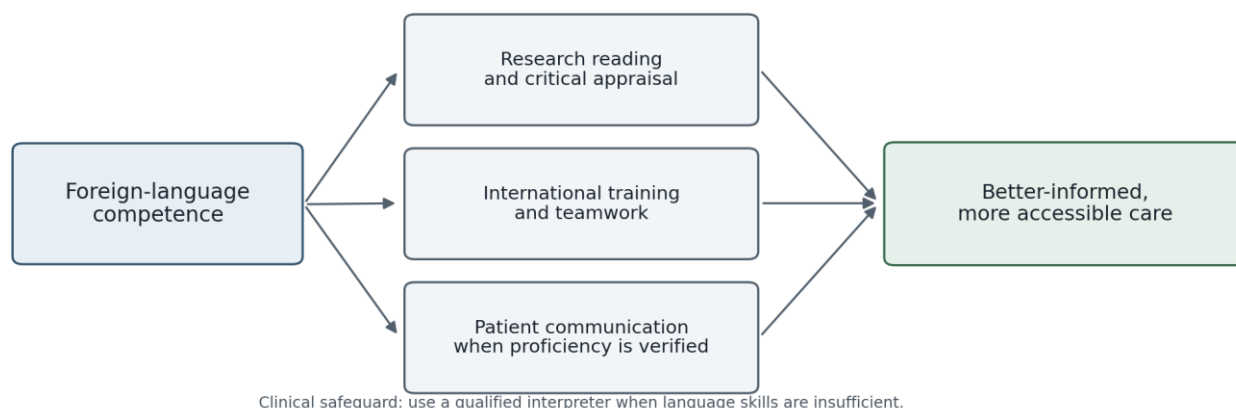


Figure 1. Routes through which foreign-language competence can support medical work.

## A four-stage lesson sequence

Stage 1 — Analyse a professional task. Present a short anonymised case, a research abstract or a discharge instruction and ask learners to identify the intended audience, purpose, essential facts and possible ambiguities. A clinical collaborator should verify the medical content before classroom use.

Stage 2 — Build precise language. Teach the terms and sentence patterns required for the task, including distinctions between technical vocabulary used among colleagues and plain-language explanations used with patients. For example, “dyspnoea” in a case note can become “shortness of breath” in a patient-facing explanation. Learners should practise checking meaning rather than merely replacing individual words.

Stage 3 — Perform and revise. Students summarise an article, deliver a brief handover, or role-play an explanation. Peers and teachers use a checklist for accuracy, clarity, audience fit, respectful tone and explicit checking of understanding. Where a scenario includes a language barrier beyond the student’s competence, the correct action is to request an interpreter and brief the interpreter appropriately.



Stage 4 — Transfer and assess. Learners repeat the task with a new topic. A portfolio can contain an annotated abstract, a revised handover script and a short reflection on a misunderstood term. Assessment should compare performance against explicit task criteria rather than count memorised terminology alone.

## **Illustrative classroom assessment**

For an article-summary task, the teacher may assign four criteria worth 0–2 points each: accurate study question, correct identification of design and population, careful description of findings and limitations, and clear language for the intended audience. For a simulated patient explanation, add a separate safety check: the learner must state when professional interpreting is needed. These criteria are a proposed teaching rubric, not a validated clinical credential.

## **Discussion**

The educational argument is strongest when foreign-language learning is treated as a set of observable professional tasks. A curriculum based only on word lists may support recognition of terms but does not demonstrate the ability to read research critically, hand over care accurately or communicate risk to a patient. Conversely, attractive spoken English is not evidence of medical accuracy. Language teachers and clinical teachers should therefore review tasks together and make the boundary between linguistic performance and clinical judgement visible in feedback.

The findings are relevant beyond English. The language that best supports a patient encounter is the language the patient understands, while the language that best supports access to a particular source may be different. Teaching materials should reflect the local mix of languages and avoid assuming that multilingualism by itself guarantees equitable care. WHO guidance and AHRQ's safety recommendations make interpreter access, translated resources and staff training part of the response [2, 7].

This article is limited by its focused, non-systematic selection of sources and by the absence of locally collected learner or patient data. The proposed four-stage sequence needs testing with clear pre-specified outcomes, such as accuracy of article



appraisal, quality of simulated handover and appropriate interpreter referral. Its effects on actual patient outcomes cannot be assumed from the studies reviewed here.

## Conclusion

Knowledge of foreign languages can widen medical professionals' access to evidence, education and collaboration. In patient care, its value depends on sufficient task-specific proficiency and a system that supplies qualified interpretation when needed. English for medical purposes should therefore combine research literacy, precise professional language, observed communication practice and explicit patient-safety safeguards.

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