

Language Proficiency Testing and the Expatriate Medical Practitioner in Malawi

Gregory H. Kamwendo

*Department of Languages and Social Sciences Education,
University of Botswana*

According to the Medical Council of Malawi, one of the conditions for a licence to be granted to an individual who wants to practise medicine in Malawi is the practitioner's ability to speak and write English fluently. This means that the expatriate medical practitioner is not required by law to demonstrate fluency in Chichewa (the national language) or any other relevant indigenous language(s). On the basis of a sociolinguistic study that was conducted at a major referral hospital in a predominantly Chitumbuka-speaking town, this paper argues that the Medical Council of Malawi erroneously assumes that English is the main language of doctor-patient communication in Malawian hospitals since the country is linguistically categorised as an English speaking African country. Yet only a minority of the population is competent in English. The national language (Chichewa), and other indigenous languages remain the main medium through which much of the health service provider-patient communication takes place. A more realistic and comprehensive language proficiency testing should cover English (the main international language of medicine) and at least one indigenous language (the lingua franca of the area in which a particular hospital is located).

Keywords: language assessment, languages for medical purposes, Malawi, English

Introduction

Language proficiency tests play a gate-keeping function in some professions and is one of the critical factors considered when recruiting medical personnel. Some countries demand certain levels of language proficiency before a foreign medical practitioner can be granted a license to practise. The health services sector in Malawi is no exception. According to the Medical Council of Malawi, a medical practitioner who seeks a licence to practise in Malawi, in addition to fulfilling other requirements, has to demonstrate the ability to speak and write English fluently. This means that in Malawi, the foreign medical practitioner is not required by law to demonstrate fluency in Chichewa (the national language) or any other relevant local language(s). This is an anomaly, given that despite being the official language, English is, in demographic terms, a minority language in Malawi. This current paper explores the extent to which it is worthwhile to demand that expatriate medical practitioners must demonstrate fluency in English before they can be licensed to practise in Malawi. In view of this objective, this paper focuses on language policy and planning at the micro level.

A case study of micro language planning, with particular reference to a major referral hospital in the Northern Region of Malawi is presented.

In Malawi, English is the official language and by extension, English is the official language of health services delivery. However, when it comes to patient–doctor interactions, as the current paper will demonstrate, it is not English but local languages that are predominantly used. This sociolinguistic situation brings into question the rationale behind having English language proficiency as one of the conditions for granting a license to an expatriate medical practitioner. The critical need for proficiency in local languages is overlooked.

First, an overview of the linguistic and socio-economic situation in Malawi and the issues involved in language proficiency for medical professionals is provided. This is then followed by a description of the research site and a discussion of the research findings on the language situation at the selected hospital.

The Linguistic and Socioeconomic Situation in Malawi

Malawi is a landlocked country surrounded by Mozambique, Tanzania and Zambia in the southern African sub-region. English is the official language of Malawi – a policy that dates back to the British colonial days. As such, Malawi is one of the so-called English speaking countries on the African continent. Since 1968, Chichewa has been the country's national language. Other widely used languages include Chiyao and Chitumbuka. The national literacy rate is 58%. In terms of gender, males have a 64% literacy rate whilst the rate for females is 51% (National Statistical Office, 1998).

Malawi is one of the poorest countries in the world. A situational analysis of living standards that was jointly conducted by the Government of Malawi and the United Nations found that 60% and 65% of the rural and urban populations respectively lived below the poverty line (Malawi Government & United Nations, 1993). The poverty situation in Malawi has continued to worsen since the release of the poverty analysis report.

Language Proficiency for Medical Practitioners

Communication barriers between clients and service providers can compromise the quality of health services. Some of the causes of communication breakdown include poorly interpreted messages and the lack of bridging languages between interlocutors. This situation can sometimes lead physicians into making a poor diagnosis and/or inappropriate prescriptions. In some unfortunate cases, loss of life can occur. Cameron and Williams (1997) argue that:

Although we may think that the primary tools of medicine are technological, the most fundamental tool, upon which all use of technology depends, is that of language. Language allows patients and care-providers to make their intentions known, a crucial step in the process of identifying a problem, investigating how long it has existed, exploring what meaning this problem may have, and setting in action a treatment strategy. Thus if problems in linguistic encoding interfere with this process, there may be important consequences. (Cameron & Williams, 1997: 419)

The critical role that language plays in health services delivery is further highlighted by the demand by some licensing bodies for certain levels of language proficiency before medical practitioners can be permitted to practise. For example, the Medical Council of Malawi issues licences to medical and dental practitioners in line with the provisions of the Medical Practitioners and Dentists Act Number 17 of 1988. According to the Act, the Medical Council of Malawi may refuse to register an applicant if in its opinion, the applicant, notwithstanding that he or she is otherwise qualified, is not fit to be registered because of his/her:

- (1) physical or mental health; or
- (2) the fact that he or she is not of good character and reputation; or
- (3) that he or she *does not have adequate knowledge of the English language* [emphasis added].

A medical practitioner needs to be proficient in the national or official language of a particular country in order to discharge his/her duties smoothly. Without such language proficiency, linguistic barriers would undermine a medical practitioner's professional productivity and efficiency. As a result, in the core English speaking countries, there is a requirement that non-native speakers of English must pass English language proficiency tests before they can be allowed to work in the health services sector. For instance, in the United Kingdom, the National Health Services (NHS) regulations require that doctors should have adequate English language proficiency. They may be required to prove their proficiency through taking the International English Language Testing System (IELTS) or any other similar language proficiency test.

In Malawi, expatriate doctors do not take any English language proficiency test. If the applicant can 'speak' English, then the Medical Council assumes that he/she will be able to communicate well when performing his/her clinical duties. This amounts to taking things for granted. In the case of doctors who come from English speaking countries, there should be no concern. However, the situation is different when dealing with doctors who are non-native speakers of English. The Medical Council of Malawi has now realised that some doctors who are non-native speakers of English, or those coming from non-English speaking countries, have problems with their English language proficiency. In view of this realisation, plans are underway to establish an English language proficiency test for expatriate doctors who are applying for a license in Malawi (Registrar of Medical Council of Malawi, personal communication).

The Research Site: Mzuzu Central Hospital

This paper is based on a sociolinguistic study that was conducted at the Mzuzu Central Hospital (MCH) in the northern region of Malawi in 2002. The hospital has a 300 bed capacity, and was officially opened on 11 November 2001. It caters for all the six districts of northern Malawi. The hospital was funded and constructed by the Republic of China (Taiwan) at a cost of \$US14 million. This hospital is part of the aid package that Taiwan offers to some African countries to buy their support in its bid to get United Nations recognition. The MCH offers out-patient treatment, in-patient treatment and specialist

treatment. The hospital has up-to-date equipment for the laboratory, X-ray department, physiotherapy department, dental unit and operating theatre.

At the MCH, expatriate doctors outnumbered Malawian doctors. This is a general trend across the whole country. For example, in 2003, a year after conducting the study at MCH, Muula (2006) found that 51.2% of the doctors in Malawi were expatriates whilst 48.8% were Malawians. At the time when data for this paper were being collected, there were 16 doctors at the MCH. The numbers of doctors in terms of their countries of origin were as follows: Malawi (3), Taiwan (3), United Kingdom (3), Egypt (4), USA (1), Tanzania (1) and Palestine (1). This means that only three doctors (18.75%) were Malawian citizens whilst 13 (81.25%) were expatriates. Among the 13 expatriate doctors, four (30.8%) were native speakers of English whilst nine (69.2%) were non-native speakers of English. All the expatriates had been in Malawi for not more than one year. None of the expatriate doctors spoke any Malawian language.

The Language Situation at the Mzuzu Central Hospital

This section presents the language situation at the MCH with the aim of determining the adequacy or inadequacy of English language proficiency that medical practitioners have to demonstrate before they can be licensed. The sociolinguistic data on which this section is based were collected through: (1) interviews with 478 clients; (2) questionnaires completed by 79 service providers; and (3) observations of the hospital environment. The questionnaire sought the following information from the service providers: professional status, age, sex, nationality, length of stay in Malawi (in the case of expatriates), mother tongue and proficiency in other languages, languages used in health services delivery, use of language services at the MCH, and linguistic problems at the hospital.

Perceptions of the Need for Local Language Competence for Expatriate Staff

As noted earlier, Malawi relies heavily on expatriate doctors. To this end, MCH clients were asked whether expatriate medical practitioners should satisfy a local language competence requirement before they could be permitted to practise in Malawi.

The majority view (93.5%) as indicated in Table 1 was that there was no need to demand local language competence from expatriate medical staff as a condition for granting them permission to practise. It became necessary to find out

Table 1 Local language requirements for expatriate staff

<i>Proficiency in local languages required?</i>	<i>Frequency</i>	<i>Percentage</i>
No	447	93.5
Yes	26	5.4
No Response	5	1.0

why the majority of the respondents felt that way. Upon being asked to justify their stance, the majority group came up with three arguments. First, it was argued that such local language requirements would act as a restriction to those foreign professionals who wanted to work in Malawi. If expatriate medical personnel decided not to come to Malawi due to stringent local language proficiency requirements, then it is Malawi that would suffer most given that it is in dire need of qualified and experienced personnel. To make Malawi attractive to foreign medical staff, so the respondents argued, the current policy of demanding proficiency in English should be maintained. After all, English is the international lingua franca of medicine (see Maher, 1986). The current policy does not ask for too much given that English has assumed a global language status. What the proponents of this view fail to appreciate is that it is not unusual to have some jobs that demand certain local language competencies. These requirements are normally set when there is evidence that without the stipulated language competence, a practitioner would be communicatively disadvantaged when he/she carries out his/her duties.

Second, it was argued that if there was a need for expatriate staff to learn local languages, then they could learn them whilst on the job. What was not specified, however, was how the language learning process was going to be accomplished. Third, it was argued that interpreters could always assist whenever an expatriate member of staff met a non-English speaking client. Some respondents even posed the question: 'What are interpreters there for?' This question assumed that there were established positions for interpreters at the MCH, yet this was not the case. Just like in other hospitals in some African countries such as South Africa (see Crawford, 1999; Saohatse, 1998, 2000), and Zambia (see Chanda, 2003) just to mention a few, interpreting at the MCH is conducted on an ad hoc basis. Most importantly, one has to bear in mind that such interpreting is potentially problematic.

English: A Communication Bridge and/or Barrier

Was English serving as a bridge or barrier at the hospital? The answer to the question is both yes and no. As a linguistic bridge, English enabled local and expatriate staff to communicate well. Local staff also found English to be the language of communication among themselves for various reasons. For instance, local staff who did not share a common local language found it convenient to communicate through English. The topic under discussion also influenced the choice of English. Due to the scientific nature of some of the discussions focusing on the medical profession, local service providers found English to be the most appropriate linguistic medium to handle such topics. English was found to be capable of handling the discussion of medical issues better than a local language. All the service providers, as members of a common community of practice, were able to interact through English as an international lingua franca of medicine. So far, we see English serving as a bridge linking people of different linguistic backgrounds.

However, there were situations at the MCH when the English language actually acted as a barrier to communication. For instance, communication with Chinese expatriates posed some problems. One of the Chinese doctors at the hospital indicated that though English is used in medical training in Taiwan,

outside the classroom and hospital environments, there are minimal opportunities for the use of English. Since there is minimal use of English in Taiwan in general, Taiwanese professionals intending to work outside their country have to learn English or improve their levels of competence in English. Though English is not an official language in Taiwan, Chia *et al.* (1998) found that both the medical faculty and students viewed English as an important language for medical studies within and outside Taiwan, as well as for a medical career outside Taiwan.

Interviews with some of the Chinese service providers confirmed their English language problems. One of the Chinese expatriates confessed that

... the most important language I cannot speak very good. Sometimes we have to discuss very deep problem, very serious problem. I have to consider some ... and try to speak and sometime I cannot speak out. That's my problem

The Chinese doctor's language problems raise concerns about his ability to contribute to professional decision making. It is a waste of scarce human resources to have qualified doctors whose services are underutilised due to the fact that they are unable to communicate effectively through English. The Chinese doctor noted that whenever there was no one to interpret, patients simply went away: 'if a patient cannot speak English, then they won't refer to me. They won't see me'. At other times, 'I tell the assistant to work with me and he can do the translation'. This meant that the expertise of the Chinese doctor was under-utilised because of the linguistic barrier. These incidents strengthen the importance and relevance of expatriates' proficiency in local languages.

A Chinese nurse interviewed appeared nervous. It was clear that she was uncomfortable with her competence in English. She was bilingual – English and Chinese. At the time of the interview, she had spent only one month in Malawi. Responding to a question on what communication problems she faced at the MCH, she cited two problems. The first problem was what she called the Malawian accent of English. As a way of solving this problem of the Malawian accent of English, she normally asked her interlocutors to speak more slowly. She claimed that Malawians speak English 'very fast'. Her second problem was her inability to speak Tumbuka. It is significant that she realised that for her to communicate well with the majority of the clients at the MCH, she needed Tumbuka, and not English. When I asked the Chinese nurse to comment on the language and communication problems she experienced at the hospital, she said: 'I hope the hospital can provide Tumbuka classes'.

Through an interview with a Malawian key informant, a technician who worked in the radiology section, a Chinese expatriate service provider who had severe language problems was learned about. The language problems were so acute that the Malawian informant felt that they spoilt his otherwise respectable professional competence. The expatriate's setback was that his proficiency in English was too low to allow him to communicate meaningfully with professional colleagues and clients. The expatriate was later replaced; though was not clear whether the decision to replace him was due to his linguistic deficiency. Whatever the reason, one thing that is clear is that the expatriate had an English language deficiency that negatively impacted on

how he discharged his professional duties. The informant described the case of this expatriate as follows:

You know the Chinese have got a problem in English. Our first radiology specialist had problems in English. So it was looking like though he doesn't know his job. In general, to say the least, he didn't assist us a lot. But the one we are having at least she did her education through English, so communication is not a problem for her.

Another Malawian service provider, a clinician, confirmed that on arrival at the MCH, some of the expatriate staff from non-English speaking countries had serious problems with English, but 'most of them now are so far familiar with English'. Since the situation in Malawi has forced Chinese expatriates to use English daily in all their transactions, their fluency had improved. The Malawian clinician elaborated: 'Yes, they had problems with English. Some of them could get you speaking in English but for them to speak out in English, it was a problem'. The clinician described his initial experiences in interacting with Chinese expatriates:

It's like you have to fill in the patches. There, I think what he has said here means A, B, C, D. But otherwise communication at the beginning was somehow a problem for some of us for who it was our first time to interact with such a society. It was really a kind of problem but they are friendly people. They are well mixing guys. So it didn't take a long time to really know their language, I mean their weaknesses.

Another Malawian service provider, a laboratory technician, also described how difficult it was for him to understand the English of the Chinese expatriates, and also how difficult it was for the Chinese to understand Malawian English:

Communication breakdown was there at first as we are of different nationality. We could not get what our friends meant and vice versa. For example, Chinese English was a problem and our English was so fast for them and it could take a long time to understand what each one of us was trying to convey.

The problem of the intelligibility of the non-native speaker varieties of English was also raised in service providers' questionnaire responses. This prompted a Malawian clinician to propose that the Government of Malawi should treat English language competence more seriously when recruiting expatriate staff, especially those coming from non-English speaking countries. He recommended that 'the government should try as much as possible to send expatriate doctors who know English for better communication and management of patients at this hospital'. This recommendation correctly points to the fact that some expatriates' English language competence was so low that it was a barrier to effective communication with colleagues.

Hospital-based Language Use

Clients were asked to indicate what they found to be the most frequently used languages at the MCH. As Table 2 shows, an overwhelming majority of the respondents cited Tumbuka.

Table 2 Most frequently used language(s) at the MCH

<i>Language</i>	<i>Frequency</i>	<i>Percentage</i>
Tumbuka	474	99.2
Chichewa	3	0.6
Ngoni	1	0.2

Table 3 Second most frequently used language at the MCH

<i>Language</i>	<i>Frequency</i>	<i>Percentage</i>
Chichewa	474	99.2
Tumbuka	3	0.6
English	1	0.2

A related question asked clients to indicate the second most frequently used language in the delivery of services at the hospital. The overwhelming majority, 99.2%, indicated Chichewa (see Table 3).

Preferred Language(s) for Hospital Transactions

Clients were asked to refer to their own linguistic capabilities and then indicate the language that they felt was their preferred medium of communication at the hospital. As Table 4 indicates, the majority said that their preferred language is Tumbuka whilst the minority view was that it was Chichewa. The results (as indicated in Tables 2, 3 and 4) mean that for service providers to work efficiently at the MCH, competence in Tumbuka is of paramount importance. The MCH is linguistically unique among Malawi's four central hospitals in that it is the only one that has Tumbuka as the most widely used language of client-service provider interaction. This is the case because the hospital is located in the Northern Region where Tumbuka is the lingua franca. The other three central hospitals in Blantyre, Lilongwe and Zomba have Chichewa as the dominant language of hospital interactions, given that Chichewa is the lingua franca in those areas.

The discussion so far has indicated that clients generally are not concerned about language or communication problems at the hospital. They seem to be so

Table 4 Preferred language for hospital transactions

<i>Language</i>	<i>Frequency</i>	<i>Percentage</i>
Tumbuka	421	88.1
Chichewa	56	11.7
Tonga	1	0.2

desperate for medical assistance that they fail to appreciate the link between language and the quality of medical services. On the other hand, service providers do see two problems: the first being that the use of different varieties of English sometimes brings about a breakdown in communication. Related to this problem is the fact that some of the expatriate service providers have very low proficiency in English. The second problem is that Tumbuka and Chichewa (not English) are the most widely used languages with clients at the hospital. To be effective, an expatriate needs to go beyond English. He or she has to learn the local lingua franca. The global language is not enough.

Summary and Conclusion

The assessment policy of the Medical Council of Malawi demonstrates a number of problems. It stipulates that one of the grounds for granting a work permit to a foreign medical practitioner in Malawi is his/her ability to speak English fluently. This policy mistakenly presupposes that English is the main language of doctor–patient interaction in Malawi. This assumption is based on the official classification of Malawi as an English speaking country. The label Anglophone country, which Malawi carries, conceals the fact that only a tiny minority of the population has competence in the language. Local languages, therefore, remain the principle media through which service provider–client communication takes place.

At the same time, even though it requires proficiency in English for medical practitioners, the Medical Council of Malawi does not actually assess the proficiency of applicants in any rigorous way. An English language proficiency test should be put in place and only those expatriates who pass this test should be licensed. While English may not be the language of doctor–patient communication, medical professionals in Malawi have to communicate in English with professional colleagues both within and outside the country. The current situation in which some expatriate doctors are unable to communicate well through English does not promote efficient medical service delivery in Malawi.

The Medical Council of Malawi, or some other authority, needs to put in place mechanisms that will encourage expatriate medical staff to learn the lingua franca (dominant language) of the area in which their duty station (hospital) is located. The idea is to ensure that expatriate doctors are able to communicate directly and effectively with patients given that most of the patients do not speak English. At some stage, a local language proficiency test should be administered. Relevant incentives should be attached to expatriates' local language proficiency.

The approach suggested here will ensure that Malawi has expatriate medical practitioners who are empowered in linguistic terms. That is, the expatriates will be able to use effectively English (the global language) and a relevant local language. Through English, the expatriates will communicate well with professional colleagues and some patients. The local language will enable expatriate doctors to communicate well with non-English speaking patients. There will be no use of untrained interpreters who sometimes fail to convey the correct message. This approach will improve efficiency in the delivery of medical services in Malawi.

Correspondence

Any correspondence should be directed to Gregory H. Kamwendo, Department of Languages and Social Sciences Education, University of Botswana, P/Bag UB 00702, Gaborone, Botswana (kamwendog@mopipi.ub.bw).

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The Author

Gregory H. Kamwendo, PhD, is senior lecturer in Language Education at the University of Botswana. Prior to joining the University of Botswana in 2004, Gregory taught in the English Department at the University of Malawi. His area of specialisation is sociolinguistics. He has published on various aspects of Malawi's language planning in journals such as *Language Policy*; *Nordic Journal of African Studies*; *Language Matters: Studies in the Languages of Southern Africa*; *English Today*; *Portuguese Literary and Cultural Studies*; and *Zimbabwe Journal of Educational Research*.