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Pragmatic Transfer in Prognosis Communication to Patients with Cancer by Chinese and Thai Oncologists

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ABSTRACT. *To identify Chinese and Thai oncologists' pragmatic transfer from L1s (Chinese and Thai) to English when delivering prognostic information to patients at different stages of cancer, this study adopts written discourse completion tasks (DCTs) and semi-structured interviews for analysis. The findings indicate that English proficiency does not directly lead to pragmatic transfer from L1s (Chinese and Thai) to English in this study. But the factor of culture, including the perceptions of death and Thai people's religious belief, influences Chinese and Thai oncologists' language uses and results in positive pragmatic transfer from L1s to English. Furthermore, the factor of the residence in English language community, the language input from American TV series, and the current environment of medical care in China and Thailand are also associated with oncologists' pragmatic development.*

KEYWORDS: *Chinese and thai oncologists; Prognosis communication; Pragmatic transfer; Discourse completion tasks*

1. Introduction

Doctor-patient communication is fundamental in clinical practice. The goal of communication is to gather information to facilitate accurate diagnosis, give appropriate counseling, provide therapeutic instructions, and create good interpersonal relationship with patients (Bredart, Bouleuc, & Dolbeault, 2005; Ha & Longnecker, 2010). Studies have shown that good doctor-patient communication can regulate patients' emotions, psychological stress, anxiety, uncertainty, and depression, facilitate comprehension of medical information, increase patient confidence and promote compliance in a treatment plan, and improve medical outcomes (Williams, Weinman, & Dale, 1998; Penson & Slevin, 2002; Rai, Han, Zheng, Yabroff, & Jemal, 2018). On the contrary, poor doctor-patient communication can result in patients' negative psychological experience, medical malpractice, treatment decisions, quality of life, and complaints against doctors

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(Thorne, Bultz, & Baile, 2005).

With the growth of medical travel, more and more patients travel to China and Thailand for medical services, resulting in intercultural communication in the hospitals (Cohen, 2012; Whittaker & Chee, 2015). English becomes a means of communication in doctor-patient encounters. However, doctor-patient communication tends to be more stressful and challenging when physicians and patients do not share the same language. This barrier may negatively affect patient's care, resulting in worse health conditions, especially in patients with serious illnesses. Patients may not comply with medication or therapy if physicians fail to explain potential side effects (David & Rhee, 1998).

Communicating prognosis in cancer care reveals that there are cultural differences in disclosure of bad news preferences. The evidence suggests that the majority of patients of English-speaking countries prefer to be fully informed of their illness while patients of Asian cultures prefer the information regarding their diagnosis and/or prognosis to be withheld (Hagerty, Butow, Ellis, Dimitry, & Tattersall, 2005). Fujimori and Uchitomi (2009) found that Asians are less likely to prefer discussions of life expectancy or survival prediction than Westerners do. Discussing life expectancy or survival prediction can be challenging for both physicians and patients. Even if patients request honest and truthful information about their illness, they tend to find it difficult to hear any bad news about death and dying. Using direct statements or communicating openly about bad news can be seen as inappropriate, insensitive, and uncaring, particularly for most patients from South America, Middle East, and Asia (Fujimori & Uchitomi, 2009). Therefore, delivering bad news in a more indirect and ambiguous way is preferable as it allows patients to maintain their hope (Kagawa-Singer & Blackhall, 2001).

Pragmatic transfer is defined as the influence exerted by learners' pragmatic knowledge of languages and cultures other than L2 on their comprehension, production and learning of L2 pragmatic information (Kasper, 1992). Pragmatic transfer can be classified into positive transfer and negative transfer. Transfer where language-specific conventions of usage are consistent between L1 and L2 is called positive transfer. Negative transfer happens when conventions and rules of language between L1 and L2 are not shared.

Research findings on the relationship of pragmatic transfer and L2 proficiency are still inconclusive. Takahashi and Beebe (1987) proposed that L2 positively correlated with pragmatic transfer. So, transferring L1 pragmatic knowledge is blocked by learners' limited knowledge of L2. The occurrences of pragmatic transfer occur more if learners have a high level of L2 linguistic competence. Learners with high L2 proficiency have acquired sufficient knowledge to express what they would like to say while learners with low L2 proficiency tend to have difficulty expressing what they would like to say in the target language (Takahashi & Beebe, 1987).

Previous studies use length of stay in a target speech community as an indicator of L2 pragmatic acquisition (Han, 2005). Scholars claim that language learners living in a target language community have more opportunities to interact in L2, which could lead to the learners' successful acquisition of pragmatic competence

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(Olshtain & Blum-Kulka, 1985; Blum-Kulka & Olshtain, 1986; Bouton, 1999). Overall, these studies suggest that longer residence in the target language community yield greater L2 pragmatic attainments. In addition, the intensity of interaction in the target language community matters in L2 pragmatic acquisition (Klein, Dietrich, & Noyau, 1995; Matsumura, 2003).

Delivering bad news to cancer patients is an unpleasant task as physicians may have difficulty responding to patients' emotions or balancing patients' hope with realism. There are some studies on how native English oncologists deliver the bad news and how native English patients with cancer perceive the information (e.g., Rodriguez et al., 2007; Robinson et al., 2008), however, there is limited literature on how Chinese and Thai oncologists communicate prognostic information to patients with cancer in L1s (Chinese and Thai) and English. This study aims to explore Chinese and Thai oncologists' pragmatic transfer from L1s to English by comparing L1s and English statements in the discourse completion tasks (DCTs) and further semi-structured interviews. The results may shed lights on a better understanding of discourse modes that are used in doctor-patient communication in Chinese/Thai and English. Moreover, the study may reveal Chinese and Thai oncologists' pragmatic transfer in intercultural communication and factors influencing their language uses.

2. Methodology

2.1 Participants

Six oncologists (three Thai and three Chinese) were involved in this study. All of the six oncologists had experiences in communicating prognosis to local and overseas patients with cancer before. Written informed consent was obtained from each oncologist prior to the study. The demographic information of the participants is listed in Table 1 below.

Table1 Demographic Information of the Participants

		Chinese oncologists	Thai oncologists
Age	25-34	1	2
	35-44	2	1
Gender	Male	1	1
	Female	2	2
Years of being an oncologist	Mean	9	3.33
Specialty		Tumor biotherapy, Gynecological tumor, Radiology	Oncology
Years of learning	5-10	0	0

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English	10-15	0	3
	15-20	3	0
Self-evaluation of English proficiency	Pre-intermediate	1	1
	Intermediate	2	2
	Upper intermediate	0	0
Received any training program on doctor-patient communication		One received one-day training program	One received two-day training program
Ever lived/studied/ worked in a foreign country		One has been studying in Houston, US for one year	No

2.2 Data collection

Considering patients' privacy and ethics in the clinic, this study adopted written DCT to collect data instead of ethnographic observation. The DCT also helped researchers specify the canonical shape of communication behaviors in the minds of oncologists (Beebe & Cummings, 1996). A six-scenario DCT questionnaire was used to elicit how oncologists presented prognostic information to patients with cancer in L1s and English. The DCT was designed with two situations based on the severity of cancer, which meant the hearer in each situation was the patient with cancer at early- and advanced-stage. Under each situation, there were three scenarios including test results, treatment, and prognosis statements according to the codebook of oncologists' communication behaviors (Robinson et al., 2008). Therefore, each participant wrote their own statements of test results, treatment, and prognosis to patients at early or advanced stage of cancer in each situation of the DCT. The DCT is shown in Appendix.

In order to investigate oncologists' pragmatic transfer from L1s to English, the DCT was translated into Chinese and Thai by two researchers, and two more experienced Chinese-English and Thai-English translators checked the translation to make sure the accuracy. After finalizing the scenarios used in the DCT, the researchers sent the questionnaire to another one oncologist (not included in the six participants) for a pilot study to make sure the scenarios and questions in the DCT were clear and unambiguous. Then the participants completed the DCT online, firstly native Thai and Chinese oncologists finished the DCT in English. Seven days later, the same participants used their L1s to complete the tasks.

After the DCTs, semi-structured interviews were conducted. All the participants were involved in the interviews.

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2.3 Data analysis

The Chinese and Thai versions of the DCT were translated into English by two researchers first. A back-translation was conducted later for accuracy and quality, which evaluated equivalence of meaning between source and target texts. The experienced Chinese-English and Thai-English translators performed the back-translation. The accuracy of translation reached 91.2% (Thai-English) and 90.8% (Chinese-English). Disagreements were discussed and final decisions were made by two researchers.

In terms of the analysis of the interviews, two researchers transcribed the interviews into texts first. Each researcher coded half of the transcriptions independently, and double-coded the other half. After coding and recoding, the categories were identified and the themes were developed from the interview data.

3. Results and discussion

3.1 Pragmatic transfer from L1s (Chinese and Thai) to English

a. L2 linguistic proficiency

In order to explore whether there exists pragmatic transfer in delivering test results, treatment, and prognosis to patients with cancer at early and advanced stages among Chinese and Thai oncologists, the texts in English and L1s (Chinese and Thai) from the DCTs are compared. The comparison shows that there are more explanations in L1s by all Chinese and Thai oncologists, including the explanations of symptoms, treatment plan, side effects, and prognostic information. However, the text size is smaller and the language is more direct in English. For example, a Thai oncologist describes the recommended treatment and the benefit of chemotherapy in Thai in detail, *"After surgery you will need physiotherapy because part of your lung will be removed. Can we avoid surgery? We recommend surgery because chemotherapy or radiotherapy cannot get rid of cancer and there's a chance that cancer grow and spread. That's why we expect you to be completely cured. We want you to consider surgery. After surgery we will meet with you again to discuss plans for chemotherapy and radiotherapy. I want to see the tissue sample test result thoroughly to decide whether to continue chemotherapy and radiotherapy. If the result seems bad, I will suggest you have 4 cycles of chemotherapy after surgery for 4 months. The benefit of chemotherapy is that it prevents cancer reoccurrence, but there are some side effects such as hair loss, vomiting, loss of appetite, exhaustion, bone marrow suppression, and perhaps infections, but this happens to only 10% of the patients."* But in English, *"The treatment plan for cure the cancer is surgery, chemotherapy and maybe radiation. The surgery can get rid the cancer. The chemotherapy and radiation can prevent the recurrent cancer. Today, I will sent you to see the surgeon for find the date of surgery. And I will see you in the next week for see the date of surgery and plan the date of chemotherapy."* It is clear that when using L1s, both Chinese and Thai oncologists give more information and the uses of

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I and *we* are more frequent. Besides giving facts, oncologists use first-person pronouns in L1s indicating their perspective of being a "group" with the patients or with their colleagues. While in English, Chinese and Thai doctors prefer using the direct language and using surgery and treatment as subjects to be objective. During the interview, both Chinese and Thai doctors admit that the reason why they use shorter and direct expressions in English is because their English is not proficient enough, and they lack the experience of communicating with foreign patients. *"It (English language) is a barrier. I find it difficult to express what I want to say using English. So I just used some English collocations and structures that I learnt before. But in Chinese, I can explain and I can use language to show my empathy and console the patients. And one more reason is the lack of experience in communicating with foreign patients."*

Translation from L1s is also adopted by most of Chinese and Thai oncologists when writing English statements because their lack of English pragmatic knowledge. A Chinese oncologist describes the process of writing, *"While writing the tasks in English, I first thought about what I would say in real situations in Chinese, and then I translated it into English. But due to my English proficiency, I can just use some simple and direct language."*

According to Takahashi and Beebe (1987), transferring L1 pragmatic knowledge is blocked by learners' limited knowledge of L2, and occurrences of pragmatic transfer occur more if learners have a high level of L2 linguistic competence. The findings support their views that the Chinese and Thai oncologists in current study do not show much pragmatic transfer from their L1s to English due to the English proficiency is not high enough. Therefore, the factor of L2 linguistic proficiency does not directly lead to pragmatic transfer from L1s (Chinese and Thai) to English in this study.

b. The stay in the English community

The previous studies provide evidence of the relation between pragmatic development and learners' residence in the target language community and intense interaction with native speakers in the language community (Eslami & Ahn, 2014). In the current study, there is one Chinese oncologist who has been studying in a cancer center in Texas, Houston for over one year. From the DCT, the experience of staying in the US shows the influence in delivering test results, treatment, and prognosis in English. When giving result statement to the patient with early-stage cancer in English, the doctor says, *"Fortunately good new is for you it's at early stage. I bless you come early."* For prognosis, *"... I guarantee that your cancer stay at early stage according to the current results... If you are confident in our treatment and believe yourself, it wins the chances of being completely cured."* To the patient with advanced cancer, the doctor uses, *"... We will try our best to help you to face it." "... So you have chance to overcome this disease." "... I also met lots of patients with advanced breast cancer being cured after treatment. So let's face it and defeat it together."* However, when delivering in Chinese, the oncologist does not adopt such expressions like *bless*, *win*, *overcome*, and *defeat*. It is clear that these expressions are not transferred from L1. During the interview, this oncologist claims that the

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residence in America influences the English use in communicating with patients, *"These expressions are from the everyday communication in the States, actually I didn't realize it until you asked. In America, doctors use positive and direct expressions to encourage patients with an affirmative tone, therefore, I also used the word 'guarantee'."* As to in L1, the oncologist also explains, *"I won't use these words to Chinese patients. In China, I do not use the words to show I'm quite certain, or the direct language."* The result confirms the previous findings that the L2 pragmatic development is associated with the residence in the target language community and the intensity of interaction in the language community (Klein, Dietrich, & Noyau, 1995; Matsumura, 2003).

c. Perceptions of death

Even though fear of death is not culture specific, but for the majority of Asians, death is viewed as a taboo subject. Thus, using direct words such as 'die', 'dying', 'death', or giving estimated survival percentages to deliver bad news about death and dying on a poor prognosis can be seen as inappropriate and insensitive. Neither Thai nor Chinese oncologists discuss death and dying using explicit words to patients with advanced cancer in their L1s. However, the word 'die' is explicitly used by one Thai oncologist in English as the doctor avoids discussing estimates of prognosis by focusing on alternative, attainable treatments and the fact that a surgery cannot be an option for the patient with metastasis ("*The surgery on every site is very dangerous and make you die so I can not sent you to have the surgery. The appropriate treatment for you is chemotherapy and hormone*."). When asked during the interview why the word 'die' is directly used, the doctor says "*I want to give clear information and I guess western patients prefer something more direct. Also, they can focus on the informed treatment options instead of worrying about their life expectancy*."

Talking about death is taboo for the Chinese (Chan, Lam, Chun, Dai, & Leung, 1998). However, "death is taboo" does not exclude a more sensitive and implicit way of truth disclosure (Mitchell, 1998). Justification of nondisclosure by the principle of nonmaleficence needs to demonstrate that disclosing the truth is a harmful act, which would cause an excessive psychosocial or spiritual burden (Tse, Chong, & Fok, 2003). For Chinese doctors, they do not use the word 'die' when deliver information to patients/relatives in Chinese and English. One oncologist mentions, *"I will not use the word 'die', or even talk about death to my patient since it is taboo in Chinese culture. In case I have to express this meaning, I will use 'cannot be saved' instead. But most of time, I won't talk about it unless the patient asks me on his/her own initiative."* Because of the L1 influence, as a result, there is no such expression of 'die/death' in delivering test results, treatment, and prognosis in English as well.

Therefore, for most Chinese and Thai oncologists in this study, the perceptions of death influence their language uses and result in positive pragmatic transfer from L1s to English when communicating prognosis to patients with cancer. What they adopt is to avoid talking about death or to use euphemistic expressions to deliver the information of life expectancy or death in L1s and English.

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d. Spiritual consolation in religion

Thai oncologists do not openly and directly use the words 'death' or 'dying' when discussing estimates of prognosis. To support the patients with advanced cancer, they adopt religious belief as an alternative mean for helping patients coping with this sensitive issue. Buddhism regards birth, aging, illness, and death as the natural process of human beings. Thai oncologists use Buddhist principles to console and indirectly talk about death and dying to make advanced cancer patients understand that sickness or death is a natural process ("*Please do not feel discourage by what happened because sickness is a natural process. You are physically ill, but do not let it affect your mental health.*" in Thai). The oncologist says *"…but don't worry about the unknown future. Let this illness be the problem of the body not your soul."* in English to yield similar purposes. In addition, doctors give reassurance that they will not abandon them only in English, for example, *"We will find the best treatment option for you."* and *"I will do my best practice for you."* But there is no such expression of reassurance in Thai.

Due to the religious belief for most Thai people, the oncologists use spiritual encouragement to console the patients. In Thai, doctors comfort the patients with advanced cancer by using Buddhist principles. As a result, due to the influence of L1, positive pragmatic transfer occurs from Thai to English, and the oncologists also use spiritual consolation in English by talking about body and soul.

3.2 Other factors influencing language uses of L1s and English

a. L2 input from American TV series Grey's Anatomy

Chinese oncologists use apologies in English when giving statements to patients with advanced cancer, *"I'm sorry to tell you the tests show there is something wrong with your health."* Being asked why they say sorry to patients, the oncologist answers, *"The expression of 'I'm sorry to tell you...' is learnt from the American TV series Grey's Anatomy. Before delivering bad news to patients, doctors in the TV show usually starts with this phrase. I adopt it as a way to show empathy. This TV show has accompanied me since I was a medical student, and doctors' communication and their empathy for patients have a great impact on me."* But there is no apology in L1, *"Instead of saying 'I'm sorry' in Chinese, I will use body language or eye contact to console my patients."* It is suggested that the language input from TV series can also be a factor that influence doctor's L2 pragmatic development.

b. The environment of medical care in China and Thailand

In the current Chinese and Thai environment of medical care, oncologists are likely to use vague expressions or avoid having prognostic discussions, especially in L1s, to maintain hope, minimize conflicts, and protect themselves from a malpractice lawsuit. The oncologists maintain hope and avoid conflicts by refraining from giving estimated survival percentages on a poor prognosis and use vague expressions instead (e.g., *"Most of the cases can be completely cured and the*

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probability of recurrence is very low." in Chinese, and *"The survival rate is not high because it is not early-stage breast cancer. I understand that you are worried. The chances of being completely cured are very slim."* in Thai). They claim that being truthful by giving estimated survival rates may contribute to loss of hope and bring about conflicts, *"If you give an exact number of survival rate or success ratio, then if something unexpected happened, that would cause misunderstandings and conflicts between the doctor and patient/relatives."* But in English, the oncologist studying in America says, *"I found Americans would accept and understand the doctors' direct language. And patients/relatives believe that doctors would try their best. If something unexpected happened, they could understand."*

4. Conclusion

This study adopts written DCTs and semi-structured interviews to explore pragmatic transfer from L1s (Chinese and Thai) to English when delivering test results, treatment, and prognostic information to patients at different stages of cancer. The results indicate that due to their limited English linguistic proficiency, the factor of L2 proficiency does not directly lead to pragmatic transfer from L1s (Chinese and Thai) to English for Chinese and Thai oncologists of this study. But the factor of culture, including the perceptions of death and Thai religious belief, influences Chinese and Thai oncologists' language uses, and results in positive pragmatic transfer from L1s to English when communicating prognosis to patients with cancer. Moreover, the factor of the residence in English language community, the language input from American TV series, and the current environment of medical care in Thailand and China are also associated with oncologists' English pragmatic development.

This study implies that the English input from various sources plays a significant role in oncologists' English pragmatic development when communicating in L2. Therefore, more proper English language input and intense interaction are essential for oncologists. Moreover, the study suggests developing oncologists' empathy that requires the doctors to be emotionally engaged and to experience the patient's attitudes as presences, rather than as mere possibilities (Spiro, 1992; Pellegrino, 1986). As one participant talked about the importance of empathy in the interview, *"Empathy is the most important thing in my work. For some patients at the final stage, the treatment they need and I perform is 'verbal' therapy rather than chemotherapy."*

This study used written DCTs as a main research tool that might produce data different from naturally occurring data. Oral data and ethnographic observation should be included as supplement for a better understanding of doctor-patient communications on delivering cancer information in natural settings. Additionally, more investigations are needed to involve more participants to identify a relationship of L1 pragmatic transfer with L2 proficiency and length of stay in the target culture and community.

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