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Review research paper

NEGOTIATING HIERARCHY: A CRITICAL PERSPECTIVE ON ENGLISH FOR SPECIFIC PURPOSES IN HEALTHCARE

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Abstract. *Although English is widely regarded as the medium of communication in India's hospitality and tourism sectors, English for Specific Purposes (ESP) has been largely overlooked in academic or occupational spaces. Despite facing an unprecedented shortage of healthcare workers following a new wave of mass migration, India is one of the top favored destinations for medical tourism worldwide. The present paper aims to critically explore and comprehensively understand the linguistic needs of nurses in the state of Kerala, India. Additionally, the paper investigates the impact of India's migration patterns on the use and changing perception of English in healthcare settings. It considers how these factors influence the role of language within the medical context and the lives of nurses. Critical analyses reveal the prevalence of generalized language training and inconsistencies in the perception of needs between two levels of stakeholders. This qualitative inquiry magnifies the transformative potency of the English language in conferring agency upon the marginalized nursing demographics within the Indian healthcare milieu. As such, it staunchly champions the imperative formulation and execution of a meticulously customized ESP program, serving as an instrumental catalyst for engendering empowerment and emancipation.*

Key words*: Critical ESP, Qualitative Inquiry, English for Nurses, Medical Tourism, Migration*

1. INTRODUCTION

Until recently, debates on providing a culturally inclusive environment in nursing education were focused on immigrant and international students. Language-specific need analysis (Cameron 2008; Bosher & Smalkoski 2002) and ESP course design (Bosher 2006; Huang & Yu 2023; Choi 2021; Yulan et al. 2021) make up the majority of ESP research in this area. Several studies highlighted the need for cross-cultural awareness in nursing education (Brown 1996; Hussin 2002; Staples 2019), aspects of pronunciation (Cameron 1998; Hussin 2002), vocabulary (Yang 2005), and grammar (Cameron 1998; Hussin 2002). Beyond immigrant and international students, researchers have now detached the scope of ESP from anglophone surroundings and localized the use of

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English in countries where it is spoken as a Second or Foreign Language (Mazdayasna & Tahririan 2008).

This leads to research possibilities in South Asian countries, especially in India, where English occupies a place of prestige and necessity. India is promoted under the "Heal in India" campaign as a medical and wellness tourism destination while trying to strengthen its ecosystem through systematic standardization and capacity-building programs for the service providers. Indeed, some of the steps proposed to enhance this sector of tourism propose that "…capacity building programs (to be) undertaken to train paramedical and non-medical staffs of the service providers for cross-cultural sensitivities (and) focused language training for select countries from where tourists are coming in larger numbers" (Ministry of Tourism 2022, 19). The Medical Tourism Association has ranked India tenth position out of forty-six destinations in the Medical Tourism Index (MTI) for 2020–2021.

Parallelly, at this critical juncture of care-labor migration, India has become one of the most significant contributors to the "global nursing care chain" (Yeats 2010). The southern state of Kerala produces the largest share of nurses working in India and abroad. Factors influencing migration include insufficient remuneration, avenues for professional development, the possibility of a better life, thence of recognition, overt discrimination, and unregulated privatization (Kumar et al. 2022, 12), among others. Many studies indicate that nurses in India are burdened with work, have a poor nurse-to-patient ratio, and work in pathetic conditions (Nair 2012, 75). Hence, migration is strategic in the case of nurses, and undeniably, nursing for them is not merely education or occupation; it is a larger-than-life plan, a "life strategy". Their choice of nursing and the decision to migrate are taken together (Nair 2012, 103).

Both migration and promoting medical tourism have one concern in common: the linguistic barrier impeding professional growth, isolating them from being members of a specific discourse community. With sufficient research in nursing especially concerning health policy and practice (S.L. Garner et al. 2015), factors responsible for migration (Thomas 2006), a profound nursing shortage (Hawkes et al. 2009; Gill 2011), the status of nursing in India (Walton-Roberts 2012), and the retention of skilled workers in healthcare settings (Ramani et al. 2013; Sundararaman & Gupta 2011), the present research addresses a bridgeable gap as it places specific English language training as possible recourse to their current predicament; it facilitates mobility and retention of healthcare workers simultaneously. While being critiqued for its "subtle aspect of linguistic dominance" (Master 1998, 720), which is "fostered erroneously by a pedagogy founded on native speakers'" (Chandran 2009, 307), this paper explores English for Specific Purposes (ESP) in the context of nursing as an indispensable aspect, assuring emancipation and recognition to an otherwise marginalized community.

2. Language in Nursing: Developments and Current Status of Research

English was first introduced as the medium of instruction for nursing courses under the recommendations made by the 'Health Survey and Planning Committee' (1959-1961). The committee emphasized the necessity of delivering degree courses solely in the English language. However, the widespread use of English in India had been contested by many scholars, who were against teaching the rudiments of a culture that was praised

as superior to their own. Indeed, the function of English in India differed from its function in English-speaking countries. In India, the intent behind learning English was, in fact, to understand and to be understood, which interestingly paved the way for the development of Indian English, although standard English was being taught concurrently. Examining the role of the English language in nineteenth-century India, Syed. A. Rahim (1986) observed the development of Indian English on account of cultural appropriation. He critiqued English in India as a power apparatus of the whole society, which is utilized as a symbol of "elitist, professional, and administrative power and authority" (286). English speaking in India is thus considered directly proportional to social class and power. In spite of the growing popularity and use of English, as per Census of India (2011) data, a mere 260 thousand people, or 0.02% of the population, listed English as their first language.

English was recognized as an official language in India soon after independence, and has since been positioned as a crucial gatekeeper to social and economic progress. Since its inception, "biomedicine has existed solely in the realm of English, (which) is a legacy of British colonial rule in India" (Narayan 2009, 236). Parallel to the research highlighting the effect of language barriers on patients with Limited English Proficiency (LEP) in the United States (Jacobs et al. 2006), Katherine Douglas et al. (2021) conducted a study on the impact of language diversity in emergency departments of several private hospitals in India and concluded that communication in healthcare settings is stymied by language diversity. The former provided evidence to design and implement language-based services to LEP, while the latter encouraged policy intervention in the diverse, multilingual nature of Indian medical practice. Although scholars emphasized the significance of clinician-patient communication, a search in Google Scholar, PubMed, Scopus, and reputed nursing journals on keywords such as 'English for nursing,' 'English for Medical Purposes,' 'English in Healthcare,' and others yielded no results in the Indian context. The insufficiency of research regarding language barriers faced by practitioners in the healthcare sector is also reflective of the lack of efforts to address similar concerns in nursing education and practice.

3. Critical Perspectives: A Theoretical Overview

In contrast to the discourse on the consequences of English language imperialism in ELT (Phillipson 1992) and ESL education (Freire 1970; Auerbach & Burgess 1985), the implementation of ESP has been proclaimed to be far more sensitive to the contexts in which it serves. Additionally, "ESP has the advantage of having limited objectives for learners who have completed general education and have mother tongues that are not at risk" (Philipson 2010, 263). The field has responded actively to the consequences of a lack of awareness of power and inequality in language education. At its outset, Widdowson (1981) critiqued the limitation placed on learners when provided with minimal language training as it inhibits their choice of occupations. Discrediting the language-centered and skill-centered models of learning, Hutchinson and Waters (1987) presented the 'learning-centered' approach, which focused attention on the learner in the process of learning. Similarly, Alderson (1994) advocated considering local aspects of any language program by rejecting the evaluation of ESP programs solely based on the convenience of experts.

Such concerns suggest that “ESP practitioners (aim to) reduce the effects of linguistic imperialism when given the opportunity than their ELT counterparts” (Master 1998, 719). Criticality in ESP is undoubtedly fostered by the foundational works of Paulo Friere (1970; 1994), which entail the learner's ability to take every day “ideological constructions of social relations of class, race, and gender relations” (Luke & Dooley 2011, 856) into deciding their own purposes in language and literacy studies. ESP thus considers learners as agents of discourse, aiding critical negotiation by repositioning the learner's role and use of English not diffidently or mechanically but 'creatively and critically.' English becomes pluralized in the hands of these learners through the rapid empowerment of minority communities and the democratization of access to the language (Canagarajah 1999,175). For instance, Long (2005) presented a workforce-inclusive method for needs assessment by expanding the scope of need analysis in ESP to less public occupations that have the capacity to greatly influence "federal, state, or local government language policies, with far-reaching consequences" (6).

Besides, critical ESP is of great relevance in need analysis (Woodrow 2022, 39). While problematizing needs, Benesch (2001) suggests a more critical approach that includes the addition of ‘rights,’ which is much more than a “reactive determination of learner needs based on institutional or expert expectation” (Belcher 2009, 9). Precisely, rights analysis is a theoretical way of interpreting power relations to consider unfavorable social and institutional conditions such as authority, control, participation, resistance, and ancestry, which are often ignored concerning target situations. Dialectically related to need analysis, rights analysis allows for the possibility of transforming and challenging the status quo, realizing that an entrant has the right to be included and accommodated.

Critical ESP questions the historical assumption that language communication is neutral. “It considers ESP in terms of issues such as race, gender, identity, and power relations. According to this perspective, discourse may be socially, politically, racially, and economically motivated” (Woodrow 2022, 37). Rooted in the idea that views critical theory as a problematizing practice, it analyzes power relations within interaction, thereby making applied linguistics more politically accountable (Pennycook 2001, 7). In *Assessing English for Professional Purposes (*2019), Ute Knoch and Susy Macqueen point out that skilled workers who come from diverse backgrounds may not be equipped to deal with what they call "language-associated risks," and a high-cultural-capital language such as English offers a competitive possibility of mobility in order to gain employment or avert other sorts of risks such as “pollution, discrimination, poor healthcare, or conflict” (14). Critical perspectives in ESP also look at these risks and enable learners to mitigate, avert, or manage language-associated risks in employment and migration.

4. The Study

4.1. Rationale

This paper is a part of a larger research project undertaken to provide a specific English course for the paramedical practitioners of medical and wellness tourism in Kerala, India. In January 2022, the Ministry of Tourism, Government of India, formulated a ‘National Strategy and Roadmap for Medical and Wellness Tourism,” which revealed that southern and western states of India have greater concentrations of

Medical Value Travel (MVT) service providers, as is apparent from the number of JCI-accredited hospitals. Analyzing the key strategic pillars to strengthen the ecosystem for medical and wellness tourism, the center encouraged addressing language barriers by delivering focused language training to the service providers. It is undisputedly a pragmatic approach, as "countries promoting medical tourism will have to devote time and resources to constantly retraining their workers, so they stay up to date" (Bookman 2007,103). Confirming the need for language-oriented education, a report by the World Health Organization titled "Review of International Migration of Nurses from Kerala, India" (2022) identified English language incompetency as the key barrier to migration along with other socio-political factors. The study also places India as one of the countries accounting for the largest shortages of its nursing workforce, which is strongly associated with their depleting income levels and substandard working conditions.

It is necessary to state that ESL education in India has been quite promising in the last few decades. The National Education Policy (2019) shed light on the functionality and fluency of the English language and emphasized the need for English training for students who intend to pursue scientific subjects at the graduate and postgraduate levels. Attempts to make English the medium of instruction have been successful in nursing education since the 1961 committee recommendations. Despite exposure and continued education in English during the early years and undergraduate studies, language remains the one factor that the nurses lack and dread. At this disjuncture, the study aims to deduce the underlying factors responsible for their plight and understand language barriers in light of the obligation of the government and educational institutions to guarantee the enfranchisement of people by providing specific language training, equipping them to meet the requirements of the healthcare sector, and encouraging social mobility. Considering the grave disregard for apt measures and research in this area, the study was motivated by the following research questions:

RQ1: What are the different communicative needs and challenges nurses encounter at the workplace? What factors contributed to their predicament?

RQ2: What are the attitudes of administrators towards the exigency of specific language training for nurses?

RQ3: What are the practical solutions to the pertinent impediment to effective communication?

4.2. Methodology

The first phase of this study included a detailed literature review along with a secondary data search. Most of the articles found were within the scope of migration and sociopolitical aspects of nursing in India; and secondary data was insubstantial. The second phase of the study used purposive sampling techniques to select participants from both stakeholder groups based on their convenience and willingness to participate in the research. This was followed by a snowball sampling method, where the researcher gained more participants from the same group. A pilot study was designed to include unstructured interviews with a select population to gain an in-depth understanding and obtain data based on insider knowledge. Following the pilot study, interview tools were modified.

Altogether, 34 participants, including 30 nurses, two administrators, and two English language trainers, were interviewed in the final stage during April and May 2023.

Twenty-seven nurse participants demanded the interview be taken in their L1 (Malayalam here). Consent forms were signed by the participants before the interview, and they were explained the purpose of the research prior to the interview. The interviews were recorded with consent and transcribed (or translated) into English. The subjective aspect of qualitative research was considered during the entire research period, and steps were taken to avoid false interpretations and biases by two methods; conducting a pilot study and gaining information from different levels of stakeholders. Data saturation was considered achieved after 20 interviews, as no new information emerged (Guest et al. 2006). However, the interview continued for another ten participants to make up for the nurses who were reluctant to give sufficient information. Accuracy and credibility were ensured during translation (Cypress 2017) and by rigorous cross-examination of data by the authors. Moreover, only applicable sections of the remaining stakeholder interviews were transcribed for this study.

4.3. Data Analysis

Qualitative analysis was conducted inductively on a corpus of 44,390 words using ATLAS. ti 23 qualitative data analysis software (Sampson & Wong 2023). Depending on the underlying research questions, aim, and methodology, the aim of the first phase of coding was to develop a "code list that describes the issues, aspects, phenomena, and themes that are in the data" (Friese 2019, 3). The text was coded into 857 codes and 490 appropriate quotations, starting with open coding (Corbin & Strauss 2015), and later grouped into thematic families. Considering this particular study, the codes have been reduced into relevant categories.

5. Results and Discussion

5.1. The Role of English in Contemporary Nursing Practice

5.1.1. Necessity or Burden?

The introduction of the English language into previously "non-English sociocultural contexts" (Bhatt 2001, 529) in India has not only perpetuated but also reinforced an existing "English-related inner-outer power dichotomy," wherein those who have access to the language have assumed a position of relative power (Ramanathan 1999, 212). The assertion of the status of English, and the challenge of ensuring language alignment in a multilingual healthcare environment in India has been an unsought result of globalization of the healthcare marketplace (Horowitz & Jones 2006)

> (English) is really important. I have only worked in Kerala. That does not mean that we get patients only from Kerala. Patients may be foreigners or speakers of different languages. Most of the time, we have no choice other than to speak in English. (Nurse 4)

The problematic nature of "the notion of choice" (Pennycook 2017) is observed when examining whether working-class individuals in the healthcare sector are genuinely free from economic, political, and ideological constraints that would enable them to freely opt for English. The celebratory accounts of global English, which perceive the language not as a product of global power structures but rather as a matter of individual choice, or the "colonial celebratory position of English" (Pennycook 2021; 1999), hold significant sway

in the medical context where English has expanded as an "instrument of communication and education in medicine" (Meher 1986, 284). Although there have been incremental changes at the microlevel in penetration of English to the high-class section of India, it is identified that "those who were once oppressed, climb higher in the ladder created by that particular social order and, therefore, find themselves in a better position to then oppress others" (Friedrich et al. 2013, 128)

> We have to talk in English while talking about procedures… most of the patients are of high social class. Although they understand Malayalam, they prefer to speak English. If we make any mistakes, they will notice. Procedures are explained to us in English. We do have translators. We need their help. Whenever we face any issue, we call them—even at night. (Nurse 6)

The fault lines of class and race that divided colonial society are evidently reflected in Indian nursing, along the lines of gender-based discrimination within this female-led profession. Nair and Healey (2006) consider the interaction between colonial and post-colonial modernities, by describing nursing as "a profession on the margins" and nurses as "menial and morally dubious low-class individuals" which is the aftermath of colonial legacy. English as a lingua franca in Indian medical context, cannot be thus, understood as a neutral medium but in the very sense the "fetishism of ELF, a historico-social dimension of how speakers in the world are possessed of various forms of capital- social, cultural, linguistic and economic- which depending on their distribution, afford differential access to English and its prestigious forms" (O'regan 2014, 539). The internalized identity of 'low class' and the opposing 'high class' (non-native patients here) is fundamentally an economic division (Block 2014) reflecting the elements of class consciousness resulting from engagement with "social class articulating with the material base of human existence" and the resultant "social relations emerging from this material base".

5.2.2. Breaking Down Language Barriers

Power operating at individual level from patient-nurse interaction is socially constructed and maintained in the workplace through the existence of an overwhelming hierarchy within the hospital structure which in turn implies a system of apparent discrimination against the sections of hospital that are lower in hierarchy (Nair 2012). Insistence on the use of English in the workplace along with the need for equitable provision of healthcare in multilingual societies require inquiry not only into the relatively overt dimension of linguistic interaction, but also a covert dimension that pertains to their respective epistemic standing. Adopting Fricker's (2007) idea of testimonial and hermeneutical injustice respectively as intralinguistic and interlinguistic communicative challenges, Peled (2017) expands the complex relations between language and healthcare, "the manner in which they are impacted- by the reality of English as global political and scientific lingua franca" (361). Testimonial injustice, arising from credibility deficit is the consequence of false belief prejudice on the hearer causing them to give the speaker less credibility than they would otherwise have given which is equated in the context of healthcare as 'intralinguistic' taking example of practitioners and patients who do not share the same first language:

> If we are talking to patients, it does not give a good impression. I usually say, "Sorry, that's not what I meant." But I have seen patients look at me, probably thinking that we

> are not educated enough to treat them. Because of that, I avoid these situations. Otherwise, I ask someone else to talk to the patient. (Nurse 23)

> Even if the staff knows beginner-level English, it is extremely challenging for them because they are tense. If a patient comes in with a headache, some nurses can't even ask them, "Do you have a headache?". That's the sad reality of nursing community. (Nurse 1)

Testimonial injustice is persistent and systematic; it operates by constantly attacking the intellectual confidence and excluding the practitioners from trustful conversation with the patients. Linguistic prejudice, unequal linguistic competence, and power asymmetries arising from these intralinguistic interaction marginalize the practitioners in their participation of the very activity of care giving by perpetuating their role as "salient by-product of residual prejudice in liberal society" (Fricker 2007, 58). Hermeneutical injustice on the other hand is when the "gap in collective interpretive resourced puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (1) which occurs in health contexts when there is an attempt to neutralize particular elements of culture and language:

> I work in the Cardiology department. Patients come for different procedures, either a pacemaker or an angioplasty. We have to give procedure instructions, including how to bathe, medications to be taken, food intake, and others. We are educating them about the procedure. If they speak Malayalam, we explain it in detail. But if they are foreigners, we reduce what has to be said. (Nurse 18)

> Sometimes, the patient is from Arab countries. We don't know their ways. If the patient is a woman, she might not want us in the room or explain details of the treatment in front of a man. They can be hostile towards the way we work. (Nurse 21)

For Peled (2017), diverse interpretations of health and sickness in various cultures can lead to a form of epistemic injustice rooted in hermeneutics, where concepts from another culture may not be acknowledged as valuable insights that can enhance the healthcare journey. Credibility deficit when coupled with conceptual void work in both ways; it could lead to patients being seen by physicians as irrational ultimately leading to a reduced level of understanding of their illness, or the practitioner's language limitations may hinder their ability to provide thorough explanations, understand nuanced patient concerns, and establish a sense of trust and rapport leading to serious disparities in information exchange.

5.2. Factors Contributing to Language Incompetence

5.2.1. Insufficiency of Nursing Education

Seen as the vehicle of upward mobility, English education in nursing could offer a possible reduction in social marginalisation and disenfranchisement that the nurses increasingly suffer in their lives for "not knowing English, or for not knowing it well in specific contexts" (Faust & Nagar 2001). Yet, English as a subject is only offered in the first semester of a four-year Bachelor's Degree program in Nursing with unspecified number of hours in the syllabus:

> We did not have a specific course for English. During the first year, we had English as a subject. We have two subjects which are not related to Nursing in our first year–IT and English. They did not teach us anything in detail other than reading up the basics (Nurse 5)

Analysing the educational evolution of ESP and its contemporary relevance necessitates a discerning and thorough investigation. At its outset, Pennycook's (1997) critiqued of ESP in academic settings for its "vulgar pragmatism" and promotion of "discourses on neutrality" regarding English as a global language, contributes to the conception of English for Academic Purposes (EAP) as a pragmatic discipline and calls for a shift towards "critical pragmatism", emphasizing the inherent political nature of language at both local and global levels. Responding to him, Benesch (2001) presented a model of EAP that offers "right analysis" as a critical alternative to need analysis which attends to "possibilities of more informed democratic participation in academic institutions, in the workplace, and in daily life. It assumes that each academic situation offers its own opportunities for negotiation, depending on local conditions and on the current political climate both inside and outside the educational institution" (60).

> The medium of instruction was in English. But that has no use when we come to the workplace. Communication is entirely different in the workplace (Nurse 18)

Critical EAP recognises the constraints of time within EAP contexts and advocates content teaching to be "more responsive to non-native speaking students" and adopt a "self-reflective stance" (Pennycook 1999). Successful integration of EAP in nursing education offers a critical advantage by empowering students to challenge workplace inequalities and make informed career choices. This approach, rooted in Freire's (1998) ideology of bridging theory and practice, could equip nursing students with the linguistic and cognitive tools to dissect disparities within the healthcare system. By fostering critical thinking and encouraging questioning, EAP enables them to recognize and confront issues of gender, race, and socio-economic bias in healthcare settings.

5.2.2. The 'Other' in Health Care

Social attitudes towards nursing in India reflects a stereotype: "the unskilled, morally suspect women doing work similar to that of servants, subservient to everyone, including the patient and everyone else in the hospital" (Nair 2012. 55). The concept of 'otherness' centered in the postcolonial discourses also accommodates social identities and struggles arising from internal line of cultural difference within the 'same culture' apart from the usual mechanisms of class formation (Spivak 2003). Indeed, formerly conceived as 'liberating womanhood into public spaces', nursing is more than an occupation for a distinct social class; it is more clearly, a 'judgement of worthiness':

> The major issue is how people view nursing as a profession. Although there are a handful of people who understand our hard work, most people consider our job as worthless. Both inside and outside the hospital, we are not regarded as a good profession. During the time of the pandemic, we were considered as angels. But now, we are thrown back to the same situation. Whenever people need us, they revere us. It has become normal for me. I know how people treat us, and sometimes I hate to go to work to receive such treatment. The wages are also minimum here. The maximum salary here is INR.25000 (Approximately 305.06 USD) per month after endless

> struggles and strikes. We work endlessly day and night, and we are paid INR.25000, which does not even make up for our basic needs (Nurse 1)

Rendered as subalterns in the face of systemic oppression, it is evident that they "cannot speak" which is in fact gesturing to the impossibility of speech to an audience that refuses to hear (Spivak, 1988). Disadvantaged across various levels (economic, social and political), Lukes (2005) characterizes this phenomenon as the 'third dimension of power' focusing on the ability to influence people's perceptions, thoughts, and desires to the extent that they willingly conform to the established societal structure, effectively avoiding any grievances. This silent compliance with the existing status quo can become deeply rooted, often giving rise to bodily emotions like shame, timidity, and guilt:

> Here, there is no respect or consideration for nurses. We studied BSc Nursing for four years. Although our knowledge cannot be equated with that of doctors, we do have enough knowledge. That's how we take care of patients. No one values these aspects. We don't have enough leave. Nurse patient ratio is also critical here (Nurse 2)

In the last decade alone, India witnessed an eruption of protests against institutional exploitation, which were met with strong resistance from government and hospital managements. As opposed to general belief, it is not medical expertise, but cultural and organizational hierarchy that dictates communication in workplace. Due to the inability to confront the oppressors, nurses' resort to horizontal violence using non-physical hostility such as devaluation, disinterest, and conflict regarding the continuation of traditional roles in nursing practice. Nurses have become ensnared in the economic structure of a society that relies on capital creation, which must continuously perpetuate conditions of subalternity to sustain itself, all the while facing a lack of access to discursive spaces (Hegel 1991).

5.2.3. Sustained Organizational Neglect

Nursing education and practice has indeed become a lucrative business in India (Tsujitha & Oda 2023). However, there exists a great disparity between working conditions of nurses in private and public hospitals in India. In private hospitals, student nurses are victims of cheap labor, which acts as an impetus for many hospitals to start nursing schools that cancel shortage of nurses and make the nursing students work for the benefit of hospitals. This also sustains the "resistance shown by the hospital management against improvements in salary structures and service conditions" (Nair 2012, 120). This disregard not only perpetuates social stratification, but also underscores a troubling pattern of negligence that demands meticulous investigation:

> We are not supposed to have any contact with the media. If there is any issue that happens within the hospital, we should not connect with the media (and) subside it within the hospital. There is no gap for language learning. They do not recognize language as a barrier for nurses. They are focused on the money; it is a business. They do not understand difficulties of the nurses. (Nurse 29)

At its core, the essence of English for Specific Purposes (ESP) necessitates scholars to address a foundational question: Whose needs are we concerned with and how are they determined? (Chambers 1980, 26). Moreover, within the context of a critical needs analysis, it is presupposed that institutions inherently operate within hierarchical structures, and those

situated at the lower rungs of the hierarchy possess a latent capacity for greater influence (Benesch 1996). Against this backdrop, it becomes imperative to scrutinize the management's stance regarding the linguistic prerequisites of nurses. According to management, language proficiency is viewed through the lens of a skill-based attribute, and they contend that their existing linguistic competencies are sufficient for their professional roles, with interpreters as a contingency if needed. Their stance is encapsulated in the following statement: "Language occupies the lowest tier of our list of priorities" (Employer, personal communication).

> The hospital management focuses on how to utilize a person to the maximum. Focus is on the work. They should provide some time for educational purposes. In an 8-hour shift, we are forced to work for 10 hours. So how will we learn? We won't get enough time to learn. Especially during night duty, we have to work for prolonged shifts of 13 or 14 hours. (Nurse 16)

The crux of this dissonance in the perception of need extends beyond mere ignorance and represents a protracted pattern of disregard and marginalization at the organizational level, which consistently tilts in favor of the employer. Language, within this organizational paradigm, functions as a tool for perpetuating the existing hierarchical structure, and by restricting access to language, the established status quo remains unchallenged. The deliberate neglect of nurses' concerns perpetuates the system's seamless operation, thereby facilitating the continued exploitation of those occupying lower strata within the hierarchy.

5.3. Reclaiming Identity through Language Learning

Ability to claim the right to speak is certainly an integral part of an expanded notion of communicative competence. Examining the relationship between learners and the social context which they occupy, Peirce (1995) explored language learning as an investment guided by motivation which presupposes that "when language learners speak, they are not only exchanging information with target language speakers but they are constantly organizing and reorganizing a sense of who they are and how they relate to the social world" (16). In this light, investing in the acquisition of the target language becomes synonymous with investing in the learner's social identity. In workplace contexts, this investment is often directed by instrumental motivation, signifying the pursuit of practical goals:

> I used to watch YouTube videos and learn English using that. When I was studying, I was unaware of the importance of English in my career. Only after I started working, I came to know about the necessity of language in my workplace, and I worked towards it (Nurse 28)

Nurses are inherently motivated to opt for simulation-based Occupational English Test (OET) training for migration and career advancement. The cost of the examination ($87) presents critical risk factor for nurses who are earning as little as INR.7000 (Approximately $84.54) per month on an average. Language tests which determine adequate language ability for the professional world considers proficiency threshold at which "someone is considered to have the minimum language ability which would enable them to cope with language demands of the professional world" (Knoch & Macqueen 2019, 10). In the age of globalization, complex mobilities have pushed English into non-traditional spaces, giving rise to new identities and intensifying the intricate interplay between wealth and risk, wherein the underprivileged have fewer chances to mitigate or

avert risks. Fear of communicative incompetence in the workplace and the ridicule following it forces the idea that the "lack of proficiency in professional language is a risk to be managed through testing" (15) while in reality, it should be managed by specific language training:

> I think it is up to us to improve our language proficiency. We have to be focused. Grammar was extremely challenging when I started off. I have no other option but to study. That's the reason we opt for exams like OET (Nurse 26).

While the primary responsibility for language acquisition doesn't fall on the nurses themselves, it squarely rests with the institutions they are part of. Nevertheless, it's intriguing to note that many nurses willingly engage in the process of mastering English and their motivation stems from a profound understanding that successful ESP acquisition is a crucial prerequisite for gaining entry into a larger discourse community. Moreover, this pursuit is considered a highly relevant element in shaping their self-identity and constructing their professional identities (Weyreter & Viebrock 2014, 153). The deliberate attempt of language learning and subsequent acquisition of a language that had been intentionally withheld from individuals, even when ostensibly pursued for instrumental or professional motives, ought to be acknowledged as a profound act of resistance in itself. This holds particular significance within hierarchical frameworks, as observed in the context of the Indian healthcare system.

5.4. Language, Mobility and Opportunities- Overcoming the Divide

> If you ask about migration to any nurse, they want to have a good future. They want a good salary. They are concerned about the well-being of their family and children which is why they learn English and move to countries in Europe and elsewhere. (Nurse 30)

In the complex vision of transnational uses of English as lingua franca, Pennycook (2007) observes that English is a language of "threat, desire, destruction, and opportunity" while contributing to social mobility of individuals. Although nurses' migration has been criticized from the perspective of "brain drain" within the context of global health inequality and "care drain" from a gendered-migration perspective (Adhikari & Plotnikova 2023), the increased employment opportunities of the global south has forced a "prudent family strategy" (Tsujitha & Oda 2023) wherein, for migration purposes, individuals encounter no barriers other than the requirement to speak in English. Due to juxtaposition of considerable resources, nurses often exhibit "stratified distribution patterns" in which "particular language resources are deployed on particular scale-levels and not on others; what is valid on one situation is not valid in another" (Blommaert 2010, 12).

The opportunity for healthcare professionals in India to migrate represents a profound transformation in their lives, encapsulating the amalgamation of their shared challenges, a fusion of "despair and hope", and a pivotal moment in the narrative of their quest for liberation (Giroux 2022). In this intricate process, the role of English language acquisition emerges as a purposeful intervention, conceived as an integral component of a wider framework of political, societal, and economic equity. It plays a crucial role in rejuvenating their capabilities and signifies a collective act of resistance by enabling them to bridge the gap. This journey fosters the acquisition of a 'language of hope', empowering them to surmount obstacles and fostering unity in their pursuit of better opportunities.

6. LIMITATIONS

The present study acknowledges that its scope is limited to nurses employed in prominent private hospitals catering to medical tourism in the southern and central regions of Kerala. While rigorous efforts were made to ensure the credibility of the findings through triangulated sources and a commitment to unbiased reporting, it is conceivable that a more comprehensive range of themes could have surfaced had a more diverse population been included. The research is descriptive and exploratory in nature, concentrating solely on speaking skills, and does not encompass a broader range of nursing competencies or factors. These limitations should be considered when interpreting the study's findings and conclusions.

7. IMPLICATIONS AND CONCLUSIONS

In his work Second Language Need Analysis, Micheal. H Long (2005) urges educators and researchers to consider learner's "academic, occupational, vocational, or 'survival' needs for functional L2 proficiency" by developing courses that are consulted and informed by specific learner requirements (20). He argues for triangulation of perceived and/or objective needs among learners by “presenting workers’, management’s, and the observer’s own perspectives on the causes of a labor dispute and on changes needed to the parties involved” (28). Accordingly, interviews with representatives from the management proved a dichotomy between the perception of language-based needs. Comparable to the observation by Jasso Aguilar (2005), this study presents a possible contradiction in the institutional attitudes towards limited language proficiency of nurses, as the managers believed that English language training is unnecessary and insignificant in this context. The internalized identity of the employees until recently had been reflective of the views that the employer had of them, invariably what Paulo Freire explains as a 'culture of silence' wherein the oppressed remained ignorant “rather than being encouraged and equipped to know and respond to the concrete realities of their world, they were kept "submerged" in a situation in which such critical awareness and response were practically impossible” (Freire 1970, 30). Due to emerging opportunities of migration and career development, the nurses are presented with a new and unparallel juncture where liberty of choice is instilled through the process of language attainment.

As an ESP practitioner attempting to intervene or expose inequitable linguistic relationships through the non-negotiable line of exclusionary policies and systemic discrimination, the planning and implementation of a particular language program faces considerable challenges. The introduction of new materials must take into consideration the relative ease or difficulty of introducing changes, as well as concerns about time, resources, practicality, and commitment to work toward a common goal in spite of power struggles and internal disagreements. The need for specialized language instruction in the nursing field, whether in education or in the workplace, is of paramount importance for a robust healthcare ecosystem. To begin with, institutions should work with ESP practitioners to proactively infuse linguistic modules into the nursing curriculum, meticulously structured to imbue students with linguistic competence alongside clinical proficiency. Concurrently, healthcare organizations could invest in an in-depth ESP need assessment to implement tailored language programs at workplace, recognizing them as pivotal investments rather than ancillary endeavors. Such strategic investments engender a workforce primed to traverse linguistic barriers and harness the transformative potential of linguistic inclusivity.

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