The Language Behaviour of the Physiotherapists in Hong Kong: Studies from a Social Psychological Perspective

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Abstract

The present study examined language behaviour of the physiotherapists in Hong Kong. It intended to construct a linguistic repertoire of the local physiotherapists with respect to six domains. Differences in perception of social power and ethnolinguistic vitality regarding different language choices were also investigated. A questionnaire was administered to sixty-one local physiotherapists. In-depth interviews were then conducted to gain a deeper understanding of their language use. Results indicated that different languages were used in different domains. Contrary to previous studies, there was no significant difference in perception of social power and ethnolinguistic vitality with regard to language choices. As a habitual language choice was far from being a random matter, the notion of domain of language behaviour helped organize and clarify previously unstructured awareness on language use.

Declaration

This is to declare that this dissertation is the sole work of the undersigned.

CHEUNG Pui Yee, Polly

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Since the time of conception of this research study, I have taken two years to complete. Time has elapsed with excitement and challenges. During the past two years, not only have I gained much research knowledge and skills, but also an insight into ways of problem-solving. Uncertainty and doubts have sometimes frustrated me. Yet, by undertaking this process I have learned precious experiences, and my learning attitude has been stirred. Being painstaking and laborious is a way through. Most important, the incentives and encouragement from others have driven me to the completion of my dissertation. From the bottom of my heart, I would like to thank all those who have sustained me during this critical period. So much I have received and so little can be reciprocated within this little space. Nevertheless, it is the only way I can express my thankfulness.

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Chapter One

Introduction

From the viewpoint of health care language usage, efficient communication depends on the therapists' correct utilization of technical-lay and cognitive-affective components, and the ability to transfer a message from speech to writing or from technical to lay vocabulary (Candlin, Leather & Bruton, 1976). An attempt to maintain this kind of contextual relevance and appropriateness in language use is not simple. Good interpersonal management skills provide a friendly atmosphere, showing sympathy, patience and a nonauthoritative manner of speaking (Gu, 1996). Language usage by the physiotherapists in Hong Kong are, however, further complicated by the present chaotic language situation in Hong Kong.

Hong Kong is an ethnically homogeneous society (So, 1987). About 98 per cent of the population are Chinese, and Cantonese acts as the *lingua franca* for the majority of people in Hong Kong (Pennington, 1994b). According to the Census and Statistics Department (1996a, 1996b) in Hong Kong, Cantonese is the most common language spoken at home, by nearly 88.7 per cent of the Hong Kong population. In addition, another 6.6 per cent claim that they speak Cantonese as another dialect. In other words, there is in total 95.3 per cent of people in Hong Kong have an ability to speak Cantonese, either as an usual vernacular, at least in some occasions.

Less than 4 per cent of people in Hong Kong are native English speakers (Census & Statistics Department, 1996a). With the majority as Cantonese speakers, English however is perceived as the "language of success" in Hong Kong, and is used mainly for instrumental purposes (Lau, 1991). Li (1996) has also described English as "an important asset", crucial for both academic success and career advancement. Despite the importance of knowledge in English for career prospect, a considerable number of Chinese English bilinguals in Hong Kong are in the "low functional" range in terms of their English proficiency (Bolton & Luke, 1990). English also remains at the level of specialized academic and professional uses, not for general social and interpersonal communication. There is even a strong social norm against using English for intraethnic communication. A general remark is that bilingual speakers prefer to "use English only in situations where they have little other choice" (Fu, 1987, p. 36).

Putonghua, the official language of Mainland China, has been taken as a variety of languages spoken only by a minority of people in Hong Kong as their first language. Not until recently *Putonghua* has its role shifted to become another "high variety" of language in Hong Kong (Pennington, 1994b). About only 1.1 per cent of the people in Hong Kong are native *Putonghua* speakers (Census & Statistics Department, 1996a). Another 24.2 per cent claim to have an ability to speak *Putonghua* as another language. Add up the number of native *Putonghua* speakers and non-native *Putonghua* speakers gives nearly a quarter of the Hong Kong population. Despite the increase in the number of *Putonghua* speakers from 18.1 per cent in 1991 to 25.3 per cent in 1996 (Census & Statistics Department,

1996b), there is still three-quarters of Hong Kong people have little or no knowledge in *Putonghua*. When speaking *Putonghua*, many people in Hong Kong have reported inability to express themselves fully and frustration at inappropriate expressions, and resulted in communication breakdown and speechlessness (Yau, 1992). *Putonghua*, even though is unintelligible to the general public of Hong Kong, is used at official functions alongside English (Pierson, 1994).

Cantonese, English and *Putonghua* are being used, in different extent, in Hong Kong. To describe the local language situation, a structure of triangular base of Cantonese, English and *Putonghua* is far too simplified. The current language situation is, in fact, much more confusing than this structure of three varieties of languages, basically because of the affective and functional diversity of these languages, and the various Chinese phonetic and writing system. As the use of English and Cantonese in Hong Kong health care settings are predominate, people from minority groups and uneducated groups receiving medical services are often at a linguistic disadvantages (Shuy, 1977). The local physiotherapists have to deal with such a complex language situation in Hong Kong. Thus, it is important to understand the underpinning strategy of language use by them.

Communication accommodation theory (CAT) (Giles, Coupland & Coupland, 1991; Giles, Mulac, Bradac & Johnson, 1987) has postulated that interactants have motivations for adapting their communication styles relative to their interlocutors. In addition, interactants form impressions and evaluations of

partners with respect to their expectations for a partner's communicative style relative to their own style. For those interactants aim at maintaining social differences with other interactants may attempt communicative dissimilarity to reinforce and reflect their differences. Generally speaking, two accommodation patterns are distinguished, they are convergence and divergence (Giles et al., 1991).

During the process of convergence, a conversant adjust his/her communicative style towards that of his/her partner. If both interactants are in consensus to mutually attempt to maintain their social differences by means of communication, they are in the accommodation pattern of complementarity. When both partners adhere to the pattern, the process is typically stable and is maintained throughout the interaction (Patterson, 1983). Communicative indicators complementarity may include the more powerful interactant speaks more slowly, with less gestural animation, and occasionally redirect the topic. The less powerful interactant may act in an opposite way. On the other hand, divergence occurs when an interactant adapts a behaviour different from that of a partner, which is aimed at maintaining a social distance from the other interactant, and gaining a more powerful position (Giles & Johnson, 1987). Different from communicative convergence, it creates an unstable communication exchange.

As therapist-patient interaction is characterized by power, the therapist may maintain a communicative dissimilarity or complementarity to reflect and reinforce their social distance (Street, 1991). Patients sometimes may maintain

expected communicative differences with reference to their perceived lower status and powerless to effect a change to in the nature of the interaction.

Studies have shown that doctors used conversational strategies to maintain dominance in their practices (Fisher & Groce, 1990; Kess, 1988; Waitzkin, Stoeckle, Beller & Mons, 1978). The doctor-patient communication is viewed in terms of a micropolitical situation, in which information control is used, at least in part, to maintain patterns of dominance and subordination. The characteristic features of conversational strategies to maintain an asymmetrical status between doctor and patient are the overuse of technical jargon, using denotative technical vocabulary without explanation, and the neglect of the patient's sociopsychological background and experiences (Shuy, 1977). Omissions and distortions are also notable in doctor-patient communication. Gibbon (1996) has found that distortions, modals and hedges appeared more frequently in the English than French language texts. This may denote language based conversational strategy for expression of institutional authority by the doctors. Definitely, the language situation in Hong Kong, which is primarily a triglossic model (Pennington, 1998), is fruitful to study the language usage. Up to present, however, no prior attempt has been made to study the local physiotherapists' conversational strategy for power dispute in the therapist-client discourse. In addition to that, there is a paucity of study of their perception of social power specific to the domain of therapist-client relationship.

Yet, the complexity of the present language situation reflects that studying language usage by the therapist-client contexts in terms of power dispute alone is inadequate. The concept of ethnolinguistic vitality and the domain of language use are complementary for a better understanding of language behaviour in communities (Grimes, 1994). A strong relationship has also been found between frequency of language use and ethnolinguistic vitality (Landry & Allard, 1994). Prominence of a given language on the public serves to indicated the relative power and status of the relative group (Landry & Bourhis, 1997). The notion of subjective ethnolinguistic vitality has been examined in Hong Kong to understand the social psychological processes underlying language behaviour (Pierson, 1994). It is contended that English is primarily used in business and education, whereas Cantonese functions as the language of ethnic solidarity, and *Putonghua* operates as the language of national unification (Flowerdew, 1998). Thus, the inclusion of perception of ethnolinguistic vitality allows the study of language usage in such a multicultural environment as in Hong Kong richer in context.

Chapter Two

Literature Review

2.1 The Language Situation in Hong Kong

Linguistically, the word "Chinese" on the whole is regarded as a language with a collection of dialects that are usually similar (Kwok, Chan & Sun, 1972). As Chinese script is based on a morphemic rather than a phonemic writing system, Chinese characters represent language units that are characterized by meaning, but not depicted by sound. The same Chinese character may be, therefore, pronounced in a wide range of forms with respect to different Chinese dialects. Among the wide range of Chinese vernaculars (such as *Chiu Chau*, *Hakka*, *Fukien*, *Sze Yap*, *Shanghainese*, etc.), Cantonese and *Putonghua* are the most commonly used ones in Hong Kong. Other than Cantonese and *Putonghua* speakers, there are approximately 5 per cent of the people in Hong Kong speak other kind of Chinese dialects as their usual language (Census and Statistics Department, 1996a; Pennington, 1993).

Other than the speech system, there is also an inherent ambiguity in the writing system when referring to the term Chinese. In addition to referring to Cantonese, *Putonghua* and other Chinese dialects, Chinese is also referred as the written forms of Chinese (Pierson, 1994; Yau, 1992). Broadly speaking, two styles of written form of Chinese can be identified: the classical written Chinese (*wenyan*) and the standard written Chinese (*baihua wen*) (Kwok et al., 1972). As

far as the words and the grammar are concerned, classical written Chinese has its own grammar and phraseology, and is entirely detached from the vernacular with its rich allusions to historical figures and teaching of traditional morals (Chen, 1993). Standard written Chinese, on the other hand, is an admixture of different varieties of Chinese, based mainly on the lexis and syntax of Northern Chinese, especially the vernacular of the Beijing area (Chen, 1993; DeFrancis, 1984). In a broad sense, *baihua* is basically equivalent in a large extent to spoken *Putonghua*.

The multiple writing and phonetic systems in Chinese are not the only source of language complexity, the situation in Hong Kong is further complicated by the fact that the majority of people are speaking in Cantonese, but writing in standard written Chinese. More is that elements of Cantonese and English are drawn heavily into standard written Chinese (Li, 1996). The folk linguistic notion that "Cantonese is used for speaking and cannot not be written" could no longer represent the picture in Hong Kong. In the study of Lo and Wong (1990), they have attempted to contrast between literacy and orality in the Hong Kong press and found that the written Cantonese became more and more popular. As noticed by Luke and Nancarrow (1992), many special Chinese characters used in the local newspapers originated from Chinese dialects, like Cantonese, tended to have limited currency. Li (1996) noted that "without certain degree of familiarity with Cantonese and classical Chinese, the reader would find it difficult to understand newspapers in Hong Kong"(p. 40). This phenomenon has indicated a dramatic increase in the presence of Cantonese elements in the local press, and the discrepancy between Cantonese and standard written Chinese. Luke and

Nancarrow (1992) even pointed out the consequence resulted from the using of Cantonese as the basic units in local press:

> On such a *baihua* base is sprinkled generously and literally elements from two other sources: Cantonese (Hong Kong style) and Classical Chinese (*wenyan*). The result is a hot-pot with many unique features of its own. It is not simply *baihua*: in fact it is no longer recognizable to *Putonghua* speakers and *baihua* users. (p. 87f)

Although Cantonese and *Putonghua* are originated from the root of Chinese, they display certain significant differences in phonology, a fair extent differences in lexicon, and less so in grammar (Li, 1996; Lou, 1992; Ramsey, 1987). The phoneme inventories of *Putonghua* and Cantonese are different considerably: 20 initial phonemes in Cantonese and 23 in *Putonghua*; 51 final phonemes in Cantonese and 42 in *Putonghua*; difference in the inventories of vowels, diphthongs and triphthongs; four main tones and an unstressed tone in *Putonghua* but 9 tones in Cantonese (Bauer, 1983, 1984, 1986, 1995; Bruche-Schulz, 1997). In terms of lexicon, Li (1990) suggested a lexical difference rate of 76.9 per cent existed between Cantonese and *Putonghua*, while DeFrancis (1984) had an estimate of 40 per cent. Some examples followed are listed to illustrate their differences. The word 'he' is '*keuih*' (佢) in Cantonese, but '*ta*' (他) in *Putonghua*. Another example is the word'ice-cream', it is '*syut-gou*' (雪榚) in Cantonese, but '*bingqilin*' (冰淇淋) in *Putonghua*. In Chinese medicine, the

layman term for inflammation of immune system is'*jit-hei*' (熱氣) in Cantonese, but '*shanghuo*' (上火) in *Putonghua*. In health care context, the laymen term for intravenous injection is'*diu-jim-soey*' (吊鹽水) in Cantonese, but '*dadiandi*' (打點滴) in *Putonghua*. Other than lexical differences, Cantonese and *Putonghua* also differ in syntax by four mains areas: the position of some common adverbs; the structure of the comparative of adjectives; the characteristics of classifiers; and the double-object-construction (Bruche-Schulz, 1997). Differences between Cantonese and *Putonghua* are not trivial. So it is not uncommon to find a monolingual *Putonghua* speaker has difficulty in understanding a monolingual Cantonese speaker verbally.

Moreover, code-mixing is a *de facto* linguistic reality in Hong Kong in recent times. With an overwhelming Cantonese speaking population in Hong Kong, code-switching and code-mixing, however, are ubiquitous (Li, 1996). A plentiful number of studies (Chan, 1993a, 1993b; Cheung, 1992; Kamwangamalu & Lee, 1991; Li, 1993; So, 1992; Tse, 1992; Yau, 1993) have documented the use of mixing of Chinese and English. There is a grey area between code-switching and code-mixing, and some scholars have made distinction between them. Refer to a number of studies (Hamers & Blanc, 1989; Kachru, 1983; Kamwangamalu, 1992; Li, 1996; Morrow, 1987; Sridhar & Sridhar, 1980), code-switching is termed to indicate switching between varieties of languages that coincide with clause boundaries (inter-sentential), while switches within the same clause are labelled code-mixing (intra-sentential). In grammatical sense, mixed code is a

simplified form of Cantonese enriched with English lexicon, where code-switching is alternative use of Cantonese and English. As far as in Hong Kong, both the code-mixing and code-switching are common social phenomena that have been dispersed widely, although code-switching is in a lesser extent and code-mixing seems to be less restricted in occurrence than code-switching (Pennington, 1994b). Although no apparent evidence of its occurrence as a first language, it is admittedly that a mixed variety of Cantonese with English lexis is common, especially in work places and education institutes.

Language use in Hong Kong is viewed as highly functional-orientated, and languages are used to communicate the values accordingly (Gibbons, 1982). English has been the internal language of official communication in civil services and in many companies. It has even been assigned as a label of elite education, wealth and power (Pennington, 1994b). But "English has a negligible social role to play in everyday Hong Kong life; it only has communicative currency in the technological, academic and, above all, the international commercial sectors" (Bruce, 1990, p. 16). One of the contributing factors for discouraging its use in inner communication is because using English among Chinese in some informal occasions is deemed as showing off (Pierson, 1987). Another aspect is that a large number of bilinguals in Hong Kong speak Cantonese as their primary language, but only have some degree of competence in English.

In the study of Lai (1993),.secondary students were found on the whole did not feel confident communicating in English in the classroom by virtue of anxiety, the lack of opportunities for speaking English in classroom communications, and low self-esteem. Teachers surveyed in a study conducted by Hirvela and Law (1991) for the perceptions of their English language ability and their ability to teach English, more than one-third of the participants did not express high confidence, and a particularly low proportion expressed confidence in their ability in relation to speaking and writing. Many of the bilinguals in Hong Kong are "middle proficiency" speakers in terms of proficiency in English. When speaking English, these bilinguals are heavily influenced by Cantonese prosody and segmental phonology, but not in the areas of pragmatic competence. These middle proficiency English speakers included tertiary educated students and graduates.

Inspite of reversion of Hong Kong to Chinese sovereignty, it is generally accepted that English will continue to dominate in business and academic English after Hong Kong reverts to Chinese rule (Berry, 1997). A questionnaire was administered to undergraduates in Hong Kong to examine linguistic and cultural identity, social, affective and instrumental attitudes, and general predictions for language use. It was noted that the status of English retained an influential role postcolonially (Hyland, 1997).

In contrast to English, Cantonese serves the purpose of internal and inner communication. Luke and Richards (1982) observed that, even in English medium schools, the language used commonly in canteens and on playgrounds in all schools for Chinese in Hong Kong is Cantonese, not English. Cantonese is used mainly as a function of low variety in Hong Kong. In an earlier paper of Bruche-Schulz (1991), the status of Cantonese was compared to that of a "banned" language. "Cantonese is not valued in its own right in the educational domain. It is not taught, and is therefore banned from the speakers' perception as a rightful and an effective means of communication in speaking and writing" (Bruche-Schulz, 1997, p. 308). Cantonese has been assigned as a low variety and has seldom been regarded as a high variety, especially for writing. It is, however, used in the family domain and there is a strong orientation of Cantonese to be used as a medium of instruction, including university students (Balla & Pennington, 1995).

A strong preference for Cantonese, even in supposedly English-medium settings, can be explained in terms of ethnolinguistic attitudes (Bruce, 1990). In order to express of their ethnolinguistic identity, Chinese in Hong Kong use their ethnic language, Cantonese in this case, within the family and other close social contexts. According to Pennington (1994b), the lack of access by native Cantonese speakers to contexts in which English is required for communication is indicative of the limited need for English in most segments of the population.

In an early study of Fu (1975), a questionnaire was administered to 561 secondary school students to survey on language attitudes. Most of the participants indicated awareness of English as an important asset. Eighty-three per cent of the students related learning of English as to secure a good job and was important to the future. The data indicated a desire to learn English, but only 36 per cent of the students agreed that spending many hours each week to learn English was reasonable. Forty-four per cent expressed an opinion about the considerable amount of time for learning English. Sixty-one per cent of the students reported feeling uneasy when an ethnic Chinese spoke to them in English, especially outside the classroom. Another 31 per cent even reported feeling hostile when they heard Chinese using English in ordinary conversation.

Lyczak, Fu and Ho (1976) used tape-recorded "match guise" technique to measure language attitudes in relation to ethnicity in Hong Kong. University students were asked to rate the speaker's perceived characteristics on various stereotypes, where the speaker spoke in English and Cantonese. Results showed that Chinese language guises were rated significantly higher on the traits of kindness, trustworthiness, honesty, considerateness, earnestness, humility and friendliness. For the English guises, the speakers were rated significantly higher on the traits of intelligence, competence, wealth and attractiveness.

Pierson, Fu and Lee (1980) administered a questionnaire to students in secondary schools to rate twenty-three items about language ethnicity on a five point scale, from absolutely agree to absolutely disagree. Data from the study

suggested strong ingroup loyalty, but realized that English had an important function for future prospects. Statements like "when using English, I do not feel I am Chinese anymore", "I wish I could speak fluent and perfect English", "At times I fear that by using English I will become more like a foreigner" were strongly agreed by the students. The ingroup Chinese variables positively correlated with the self-ratings on the variables in the Cloze test, where the respondents were allowed to write a few words about the attributes of the speakers in the tape, and they were "able and far-sighted", "humble and polite", "motivated for success", "frank and honest", and "trustworthy". Outgroup variables, "gentleness and graceful", "logical and wise", "trustworthy", "hardworking", and "self-confident", were all correlated significantly with the Cloze test.

The language attitudes of the secondary schools students were further examined with the use of an enhanced matched guise technique in the study conducted by Bond (1985). Subjects were allowed to look at a photograph of the speakers and listen to three Hong Kong Chinese and three native English speakers using two language guises. The speaker was rated as more friendly, honest, humble and diligent when speaking Chinese than when speaking English. The Chinese speaker was rate more negatively when speaking English but the English speaker was rated more positively when speaking Cantonese.

Similarly, Pierson and Bond (1981) studied language attitudes of sixty-four Chinese undergraduates about ingroup-outgroup ethnicity and language. Each of the two groups of eight students were interviewed by either of the two

Chinese and two American male interviewers. The students had to fill out a questionnaire about their general language competence. Statistical analysis suggested there were effects for language, ethnicity and topic. Students reported to be more confident when using Cantonese than using English, and were more confident in discussing the topic on friendship than cultural differences. The subjects also reported more alert when using English than Cantonese and discussing friendship, but not on cultural differences. They revealed feeling more respectable when using English than Cantonese.

Gibbon (1987) conducted an investigation of language attitudes of the university students with the use of mixed-guise technique. It was found that English was used by the Chinese speakers for gaining status and impression of Westernization. Cantonese was used for humility and solidarity. The mixed code guise was rated negatively, such as "ill-mannered", "aggressive", "showing off", "proud", "ignorant", "not good-looking" and so on. The mixed code speaker was, however, found being scoring more highly than Cantonese guise on the status and Westernization factors. Mixed coded guise was rated the negative attributes of Cantonese guise but the positive attributes of English guise, except "proud". Bolton and Kwok (1990) also performed a verbal guise on 131 university students and asked them to rate the six tape-recorded speakers in six varieties of English, including a range from high form to low form. Greater prestige and recognition of British and American accent were found. More male students preferred local accent whereas more female students preferred British pronunciation.

Students from the City University studying different courses were found to have distinctive pattern of attitudes towards English and Chinese (Balla, 1991). The majority of the students perceived English-medium education was crucial to their future prospects and important to improve English skills. But in the study of Lai (1993), among the 487 university students, they on the whole did not feel confident communicating in English in the classroom. In the study of Walters and Balla (1992), university students in non-science fields appeared to be more confident in using English than the students studying sciences.

Yau (1992) reported a study about the attitudes of secondary students, tertiary students and principals towards *Putonghua* and found that the majority disagreed *Putonghua* to be designated as Hong Kong's legal vernacular after 1997, and they perceived the majority of people in Hong Kong would opposed the designation of *Putonghua* as the legal vernacular.

A questionnaire was administered to Hong Kong undergraduates (N = 900) to investigate general predictions for language use. Students found English valuable and they were not resistant to Western culture. Also, they did not show greater affinity to Chinese values symbolized by *Putonghua*. It was noted, however, that the status of English as a component of the Territory's identity remained, and retained an influential role postcolonially (Hyland, 1997).

A survey of attitudes of students, teachers, and parents on the use of English as a medium of instruction in Hong Kong secondary schools indicated that students and their parents consistently valued English over Chinese as a medium of instruction, whereas teachers generally regarded instruction in Chinese was more effective (Tung, Lam & Tsang, 1997).

From the studies discussed above, the attitudes of both the students in secondary and university students in Hong Kong have a desire to learn English as an important asset, but ethnically orientation to their Chinese identity.

As a result of the functional differentiation of Cantonese and English in Hong Kong and the social differentiation of Cantonese speaking population and English speaking population, code-mixing and code-switching are emerged in a sense to integrate functional, social and psychological attributes of the respective languages. Mixed codes also equalize and minimize power differentiation between native English speakers and Cantonese speakers, and integrate the attributes of the two ethnic groups.

Different disciplines and occupations are different in the needs for English. In certain professional and specialized fields (e.g. science and law), Cantonese speakers may not know the Chinese equivalent term. Social workers in Hong Kong, where their clients are mostly less well-educated, have little need for speaking English (Lin, 1990). Other professionals, like architects and fashion designers, response more frequently in English. For the physiotherapists in Hong

Kong, their clients are mainly Cantonese speakers. The health care team members, however, are almost educated in English.

Other than serving the academic purposes, secondary school teachers switched from English to Cantonese to perform a switch in the role-relationship with their students (Lin, 1990). In the tertiary education, the communication started with English in lectures, then mixing of English and Cantonese for discussion and tutorials, and moved on to less organized and personal interaction in Cantonese (Pennington, 1992). The mixed code was also documented in the studies of in Gibbons (1979a, 1979b, 1987) for many other "domains of modernity" such as contexts about computer, fashion, music, motor car and so on. In the domain of computer discourse, for instance, was full of technical jargon. Li (1996) documented insertion of English lexicon into Cantonese in fashion discourse. Common vocabularies like wet look, grunge look, rave, polyester, rayon, Giorgio Armani and so on were everywhere in this domain. Luke and Richards (1982) found that an English word and its Cantonese equivalent differed in affective meaning. Certain middle-class Cantonese speakers may prefer to use such English terms as pill, condom, period than the Cantonese term.

Generally speaking, mixed codes were found to be endowed with meaning, marking of role-relationships and represented in-group solidarity (Cheung, 1984). It further differentiated people in Hong Kong of having knowledge in English and those who did not, and Cantonese united people of those classes.

Currently, the role of *Putonghua* is shifting to become another high variety due to political reasons (Pennington & Yue, 1994). Lung (1997) investigated the attitudes toward Cantonese and *Putonghua* in a sample of Hong Kong residents. A matched guise test in which Cantonese and *Putonghua* speech samples of a bidialectal male were evaluated, and a questionnaire and interviews were also administered. Results indicated that a general agreement on the importance of Cantonese as an everyday vernacular, where *Putonghua* was accorded as a language of domains and was important for career advancement. Subjects ascribed a higher status to *Putonghua*. But the recent introduction of *Putonghua* further complicated the existing language situation.

The existing general profile of language usage in Hong Kong is basically three varieties but two languages (二文三語): Cantonese, *Putonghua* and English for the speech system, but Chinese and English for the writing system. Mixed code in the recent two decades has also been introduced into the present language system in Hong Kong. Regardless of the size and nature of the code-mixed English unit into Cantonese, code-mixing symbolized one's bicultural identity without committing either to Chinese and Western culture (Li, 1996).

Hirvela (1991) has labelled the local language situation as "linguistic schizophrenia". Most of the people in Hong Kong are trying to maintain a balance in linguistic force between Chinese language and English language (Lau, 1991), with regard to the conception that Chinese as the language of personal communication and ethnic identity, and English conversely as the language for

prosperity. Although the functional division between English and Cantonese is consistent with the model that English is a high variety and Cantonese is a low variety, there are some more complications. Another dimension is that Cantonese is deeply rooted as the local vernacular, but possible imposition of *Putonghua* as the official language. Official Government policy has already stipulated the increasing use of Chinese, but this still begs the important question: which Chinese?

T'sou (1985) in an earlier time has already identified two particular symptoms of linguistic schizophrenia in Hong Kong. The first one is "language fatigue". People in Hong Kong are under the pressure of learning English as an institutionalized non-native language in this unnatural environment. Besides, "cultural eunuchs" are resulted from superficial exposure to Western culture but deeper penetration into Chinese values and culture, may unfortunately lead to cultural impoverishment, knowing English but without any understanding of the Western culture. Under these circumstances, "linguistic inertia" may be induced, which precludes any further linguistic development (Hirvela, 1991). These schizophrenic elements accentuate the complexity of language use in Hong Kong, ranging from education to workplace (Pennington, 1994b).

2.2 Language Use in Health Care Settings

Rarely do bilinguals have equal abilities in languages they acquired (Roberts, 1996). Different languages, in a multilingual speech community, may serve for distinct purposes, depending on the nature and content of the interaction (Breitborde, 1983; Fishman, 1965; Fishman, 1972). In health care communication, two specific kinds of communicative behaviour can be identified: instrumental and affective behaviour. Instrumental behaviour is basically technically based and orientated in the direction of problem solving (Hall, Roter & Katz, 1987), and affective behaviour is used to establish and maintain a positive relationship between the doctor and the patient (Ong, Haes, Hoos & Lammes, 1995).

During health care consultation, any treatments or advice given out by health care professionals are based not only on the physical consideration, but also on psychological and social aspects of a client (Bochner, 1983). Physical examinations help health care professionals gather necessary information for prescription and treatments. Careful sorting out of relevant information by the health care professionals from the discourse with their clients may provide them plenty of data of what the individual needs and concerns of their clients. Clients provide therapists of their medical history, social backgrounds and concerns, and by which the therapists respond accordingly (Ong et al., 1995; VanCott, 1993). In addition, health care services are mainly collaborative work. Health care professionals may quite often need information of other health care professions and share their professional knowledge. They have to correspond to messages

given out by other health care professionals in health care settings.

Verbal communication thus acts as one of the fundamental tools in a health care context where health care professionals and clients exchange their information (VanCott, 1993). One of the determinants of the success of a helping process in health care consultation is a substantial understanding of the needs and concerns of their clients, in addition to the possess of adequate professional knowledge and skills by the therapists (Cockman, Evan & Reynolds, 1992).

The flow of information in a discourse is cyclic. Both parties are responding each other (Boscolo, Bertrando, Fiocoo, Palvarini & Pereira, 1995). Any misunderstanding or misconception occurs in a discourse may lead to communication breakdown, and hinder the cyclic flow of information. Inefficient communication or misunderstanding happens in health care setting may then endanger the quality of health care services. Doctors, nurses and some other professionals have already started looking into topics of communication for years (Beisecker, 1990; Candlin, 1995; Robins & Wolf, 1988; Schneider & Tucker, 1992; Siminoff, 1989; VanCott, 1993). Little research has been undertaken to explore issues about communication in the profession of physiotherapy, not to mention the present situation of the local profession. Physiotherapists, as team members of health care services, need efficient communication with their clients, as well as with other health care team members. Besides, as health care professionals, they also have to keep abreast with versatile and ever changing demands for improvement in practice. The paucity of research in this area lays a need of

studying about it.

Several studies reported that problems in communication between doctors and patients. Pendleton, Brouwer and Jaspars (1983) recorded 79% cent of the problems concerning with communication involved the transmission of information. In that study, doctor-patient interactions in consultation were analyzed. Nearly 22% of the consultations contained some communication difficulty for doctors. The most powerful predictors for communication difficulties were self-tension and perceived tension in patients.

A survey of 40 doctors, 60 health support staff, and 120 English patients were conducted to investigate the understanding of common medical and psychological terms (Hadlow & Pitts, 1991). Significant differences in levels of understanding were found between these groups, and the widest gap in understanding was shown for common psychological terms, 70% for physicians while 36% for patients. Such differences could cause difficulty in effective doctor-patient communication.

In a study of doctor-patient interactions, transcripts investigated were of audiotaped consultations in medical institutions in China (Gu, 1996). Goal-directing behaviour were examined and showed that doctor's discursive strategies were characterized by the need to elicit information, problem-solving and a display of interpersonal management skills, but patients adopted a deferential

position and was expected to submissively respond to questions posed by the practitioner.

Analysis of language use by doctors and medical students in teaching hospitals indicated that objectivity was the most striking characteristic of doctors' language use when talked to patients in a formal and informal setting. It was suggested that doctors should revise their language use so as to reflect that medicine was not only a scientific way of knowing, but applying to human beings (Donnelly, 1986).

Inappropriate communicative strategies and their effects were assessed in counselor-patient interaction. (Youssef & Silverman, 1992). Conversational extracts indicated two major problems were the doctor's taking the role as an information giver by asking questions to which the patient expected answer, and using street slang instead of the patient's own terms for the description of sexual practices and anatomical reference.

Uses of medical language and everyday language between patients and health care professionals were studied in a hospital setting (Bourhis, Roth, & MacQueen, 1989). Doctors reported using mostly medical language with health professionals, but everyday language with patients. Student nurses reported using an equal mixture of medical language and everyday language with each other, medical language to doctors, and everyday language to patients. When discussing medical issues, it was difficult for doctors to differentiate clearly between the two

forms of language. Medical language was regarded as a source of problems for patients, while everyday language promoted better understanding for patients.

Language barriers between doctors and patients from different language groups were also examined in a few studies. Holden and Serrano (1989) demonstrated that language barriers between a pediatrician and parents of children from a non-English speaking family gave rise to a barrier in the doctor-patient relationship. But the presence of a translator introduced problems like privacy and misinterpretation of medical information by the translator.

Doctor-patient interaction in a group of native English speakers were compared to a group of non-native English speakers (Ranney, 1992). Scenarios of interaction with doctors involving native English speakers were compared with those involving Hmong refugee patients who were fluent in English. Results showed that the Hmong subjects had considerable knowledge for doctor-patient interaction in United States, but differed from the native English speakers with less interest in obtaining information and in their diagnosis in their discourse with doctors.

The discourse of French and English written guidelines in doctor-patient interactions was analyzed (Gibbon, 1996). Sample information was distributed to patients in Ireland, England, France and Belgium. It was showed that objectivity and impersonality were maintained through syntax, whereas authority and competence were established mainly by lexical choices and denotative technical

vocabulary. In the French tests, the untranslated English terms were often misrepresented.

The use of verbal and non-verbal communication skills by the physiotherapy students was investigated. Results suggested that the students regarded themselves had sufficient knowledge of interpersonal communication, and considered communication skills important during the treatment. But it was demonstrated they had not adequately equipped with the skills and overestimated their clinical use of interpersonal communication skills (Dockrell, 1988).

The value for a sick person to use one's mother tongue in health care provisions which perhaps is the most disturbing and emotionally fraught situation (Roberts, 1996) have far-reaching implications for health care education as well as health care practice in Hong Kong. It is necessary to ensure the curriculum allows students to explore and challenge their knowledge, attitudes and skills in relation to the development of practices that are linguistically and culturally sensitive to working in a multilingual community. It is also important that the local health carers understand the patients not only of their cultural backgrounds, but also to recognize the effects of language use on the people they care for.

Underpinning the interpersonal relationship between health care professionals and clients is communication skills in addition to a well-founded clinical knowledge base (Candlin, 1992). To prepare the health care professionals to meet the demands of caring for individuals in a dynamic and multi-cultural

society, educators, clinicians, researchers have to join hand in hand to undermine their awareness on the importance of communication in health care settings.

The communication process of the physiotherapists in health care settings in Hong Kong is a fruitful area of research. Owing to the present cultural, economic, political, social and linguistic situations, physiotherapists in Hong Kong may too experience a schizophrenic language situation similar to the general public (Hirvela, 1991). With the return of sovereignty to Mainland China in 1997, uses of the China official language, *Putonghua*, has currently increased (Yau, 1992). This kind of linguistic chaos happens in health care context causes predicament in communication. The medium of instruction of the Physiotherapy course in Hong Kong is English. This means that English is the main instrumental language of the physiotherapists in Hong Kong. Most clients, however, speak Cantonese since they are mainly from the Hong Kong population. In addition, the soaring number of new immigrants from Mainland China, some of them as patients while some of them as health care professionals, speak *Putonghua* only. Yet there is still a large proportion of the tertiary students professed to have little or even no knowledge of *Putonghua*.

The chaotic language situation has also aroused concerns in the local nursing profession. Professor Martinson, Chair and Head of Department of Nursing and Health Sciences at the Hong Kong Polytechnic University, revealed that some of the nursing schools had reverted to use Chinese as medium of instruction to accommodate the declining language standard of students in Hong

Kong ("Admission requirement," 1997). She suggested that Chinese might not be the most ideal medium of instruction, and there were many references were still in English.

Prior to strategies or resolutions can be made to improve the present language situation in the local health care contexts, an exploration of the language landscape of the local physiotherapy profession is essential (Chen & Chen, 1990).

2.3 Ethnolinguistic Vitality and Language Behaviour

The concept of ethnolinguistic vitality (EV) was introduced to reflect the status or position of ethnic groups (Giles, 1978; Giles, Bourhis & Taylor, 1977; Giles & Johnson, 1981, 1987). Giles et al. (1977) described the vitality of an ethnolinguistic group was that which made a group likely to behave as a distinctive and active collective entity in intergroup situations. It was proposed that the more vitality an ethnolinguistic group had, the more likely the group would survive as a distinctive linguistic collectivity in multilingual settings. The vitality of ethnolinguistic groups could be conveniently assessed by (a) status, (b) institutional support, and (c) demography (Giles, 1978).

Very briefly, the status variables were those which pertained to an ethnolinguistic group's economic and social status, its socio-historical prestige and the status of the language used by its speakers locally and internationally. Institutional support factors referred to the extent to which a language group enjoyed formal and informal representation in the various institutions of a

community, region or nation. Institutional support also included group members' control on their own institutions such as the church, the educational system, the local/regional economy, cultural institutions, the mass media and the political system. Demographic variables referred to those related to the sheer number of ethnolinguistic group members and their distribution throughout a particular urban, regional or national territory. Group's rate of immigration and emigration, the group's rate of endogamy and birth rate were also included. The model delineated as subjective ethnolinguistic vitality and objective ethnolinguistic vitality. Objective group ethnolinguistic vitality based on available data on group membership and activities, while subjective group ethnolinguistic vitality based on the perception on societal position by its group member.

Bourhis, Giles and Rosenthal (1981) proposed that group members' subjective vitality perception was as important as the group's objective vitality. Subjective vitality perceptions played a mediating role in accounting for group members' intergroup strategies, language attitudes, language behaviours and the degree of ingroup identification (Johnson, et al., 1983). Bourhis et al. (1981) devised an instrument, subjective vitality questionnaire (SVQ), to access individuals' perception on ethnolinguistic vitality in intercultural contexts. SVQ was administered on different ethnolinguistic groups (Bourhis & Sachdev, 1984; Clement, 1986; Hogg, D' Agata & Abrams, 1989; Labrie & Clement, 1986; Sachdev, Bourhis, Phang & D' Eye, 1987).

Perception on subjective ethnolinguistic vitality was tested among Anglo-Australians and Greek descent in Melbourne (Giles et al., 1985). Results indicated that quite complex cognitive representations, the two groups agreed that Anglo possessed more vitality on certain status and institutional support, but disagreed about each other's sociostructural positions. The two ethnic groups also weighted the SVQ items differently. Both groups downgraded the vitality of the outgroup and upgraded correspondingly the positions of their ingroup. Moreover, the Anglo accentuated the differences between the two groups for status and institutional support factors. These findings support for the social psychological reality of the notion of perceived vitality.

Bourhis and Sachdev (1984) conducted a study to examine the perception on ethnolinguistic vitality of Italian Canadians and English Canadians, and their language attitudes. SVQ results of the study showed that subjective perception did not necessarily match objective ethnolinguistic vitality. The Italian group and the English group were not consensual in their group status. It was also found that equal and majority setting did have an impact on language use.

Past studies consistently demonstrated the relations between ethnolinguistic vitality and language behaviour. In the study of Clement and Noels (1996), they compared English-Canadian with French-Canadian on their in-group values and language use of second language in public and private stances. Results showed that ethnolinguistic vitality was important for interethnic contact and linguistic self-confidence.

The relationship between linguistic landscape, ethnolinguistic vitality, and language behaviour in multilingual settings was examined in a sample of Francophone Canadian (Landry & Bourhis, 1997). Visibility and salience of language on public and commercial signs were influential on the degree of ingroup language use. Another study was conducted in which the SVQ and a home and school language background questionnaire were completed by students in Toronto (Feuerverge, 1989). Data analysis showed that more extensive first-language use at home was associated with more positive perceptions on ethnolinguistic vitality.

The extent of language behaviour influenced by subjective ethnolinguistic vitality and linguistic contacts was tested among Italian Australians with the use of questionnaire (Hogg & Rigoli, 1996). Language behaviour was associated with language support from institutes and ethnolinguistic identification, but not with linguistic contacts. Contrary to previous studies, subjective ethnolinguistic vitality was found to have little relationship with language use.

The contexts and conditions of ethnolinguistic research conducted in Hong Kong were quite different from other studies on ethnolinguistic vitality in a way that the research studies about Hong Kong people focused mainly on Chinese (Pierson, 1994). In Hong Kong ethnolinguistic vitality study was first conducted by Young, Pierson and Giles (1986) with the use of a local version of SVQ. It was found that Chinese students acknowledged that Westerners in Hong Kong possessed more status, and more institutional support the use of English. However,

subjects overevaluated the international importance of the Chinese language and the political power of their ingroup. Academic specialization of the students was an important determinant of ethnolinguistic vitality perceptions.

A new version of SVQ adopted in Hong Kong, SVQ-II, was developed for Hong Kong to examine perceived group vitality in Hong Kong on three levels with respect to the three varieties of languages: Cantonese, *Putonghua* and English (Pierson, Giles & Young, 1987). The results revealed that among the 53 university students in Hong Kong, English was perceived more important than Cantonese, was more important for their children's future than *Putonghua* and Cantonese. English was also high regarded internationally, and used prominently in education, in media and business institutions. The subjects perceived Hong Kong Chinese identity as more important than Chinese identity, and disagreed with the notion that *Putonghua* speakers were the only Chinese. The Chinese people were perceived having greater control over the local economy and prouder of their cultural achievement, but Westerners had more political power in Hong Kong than the Chinese. It was perceived that Chinese would be stronger in Hong Kong 20 to 30 years later and English and *Putonghua* would be stronger than Cantonese in the future Hong Kong.

Contrary to the attitudes of university students, secondary school students in Hong Kong have a strong preference for Cantonese, even in English medium settings. Bruce (1990) suggested it was "less to do with curricula, classroom methodology or the quality of teaching, and more to with

ethnolinguistic attitudes and the perceived roles and values of the ingroup and outgroup communities and their languages" (p. 10). The Cantonese speaking population in Hong Kong have been found to be high in ethnolinguistic vitality (Giles & Johnson, 1987; Pierson, 1987; Pierson, Giles & Young, 1987), and they maintained their ethnolinguistic identity and diverging from outgroup speakers. An observation made by Yang and Bond (1980) was that Chinese bilinguals in Hong Kong responded with more ingroup values to a questionnaire presented in English than when with the same questionnaire presented in Chinese. It was suggested that the subjects affirmed their Chinese ethnic identity when using the second language.

Pierson and Chan (1984) attempted to measure the relationship between perceived taking a reading test in Chinese and English and subjective evaluation of ingroup and outgroup ethnolinguistic vitality using the SVQ. In their study, 132 males and 163 females from two English-medium schools in Hong Kong were subjected to either English reading test and the Chinese reading test by random. A Chinese language version of SVQ were then administered to them. Analysis of the data showed that students taking the English reading test perceived the amount of Chinese used in government service was higher than the estimate made by the students taking the Chinese reading test. It was also found that students who scored higher on either the English or Chinese reading test perceived the Chinese political power in Hong Kong, and the strength of Westerners and Chinese in Hong Kong were higher than the estimates from the student who had lower scores in the reading tests.

Ethnolinguistic vitality provides an insight into the role of dominant and minority languages in Hong Kong. Such objective social psychological data also contributes to more understanding of complex social processes (Pierson, 1994). As its relationship with language behaviour is demonstrated, thus it is important for the study on the language behaviour in the local situation.

2.4 Social Power and Language Behaviour

According to Mintzberg (1983), the most representative framework for studying social and interpersonal power was the typology of bases of social power originally developed by French and Raven (1959). In this typology, social influence was defined "as a change in the belief, attitude, or behaviour of a person – the target of influence, which results from the action, or presence, of another person or group of person – the influencing agent" (Erchul & Raven, 1997). Social power was defined as the potential of social influence of an individual to change the beliefs, attitudes, or behaviors of another (Galinsky, Rosen & Thomas, 1973; Imai, 1993; Raven, 1992). The original model of bases of social power (French & Raven, 1959) differentiated five bases of social power: reward power, coercion power, legitimate power, expert power, and referent power. Informational power was originally listed as a form of influence, but was included subsequently and formed a power typology with six bases of power (Raven, 1965).

Legitimate power was defined as that power stemmed from internalized values in the influencee which dictated that the influencers had a legitimate right to influence on him and he had an obligation to accept this influence (French &

Raven, 1959). Legitimate power was most obvious when it was based on some formal structure, a supervisor influencing a subordinate or a higher ranking staff influencing another staff of lower ranking. Besides, other forms of legitimate power drew on social norms. The legitimate power of reciprocity refers that the influencer expected the target feel obliged to do something (Gouldner, 1960). The other form was legitimate power of equity (Walster, Walster & Berscheid, 1978). This form of legitimate power in fact was a mode of compensatory norm. For both the legitimate power of responsibility or dependence, according to the norm, we had some obligation to help others who could not help themselves, or others who were dependent upon us (Berkowitz & Daniels, 1963).

On the other hand, expert power was based on the perception by the influencee that the influencer had some special knowledge or expertness. Both of these bases of power were originally examined only in the positive forms. We also assumed that the expert knew the best and followed the decision he made, even if we did not understand the reasons. It was particularly true in the scenario of medical consultation, the doctor prescribed a treatment protocol for the patient. Preparatory stages for access to social power may be necessary for some of the bases of social power (Raven, 1992). "Self promotion" was one of the preparatory devices for expert power. The supervisors, for instance, told the workers of the amount of training and experience they had. Physicians, attorneys and other professionals by displaying of diplomas attempted to gain expert power.

Weiss (1986) proposed an ideal doctor-patient interaction should be in a way that doctors and patients mutually agree the helping process. It aimed at sharing information and achieving the goal of helping the patient, communicating with each other in an egalitarian manner, and patients' involvement in decision making. Complementarity and convergence, therefore, were exhibited in the process of helping process. By the possess of medical knowledge, doctors were regarded as experts and patients relied on their help. Doctors were influencing agents and more or less dominant with patients. Typically, during the medical consultation doctors and patients created complementary communicative pattern (Freeling, 1983).

Communication in health care context involved expression of needs and concerns by the patient (Spaniol & Cattaneo, 1994). But the choice of a language of a bilingual in health care setting is manifold, and affected by personal attitudes, identity, power relationship and language status. It is important to aware the power relationships inherent in choice of language in the health care setting.

Reciprocal topic-transition was assumed as a communicative strategy to share power between doctor and patients (Ainsworth, 1992). Topic transitions in medical encounters between doctors and female patients in a private practice setting were examined. Results showed that doctors were more likely to exercise power than were patients. Female doctors exercised unilateral power more frequently than male doctors.

An analysis of recordings of medical consultations in an outpatient setting showed that doctors attempted to preserve power in the doctor-patient relationship (Waitzkin, 1985). Doctors withheld information and maintained uncertainty by spending little time on delivery of information to patients. They also underestimated patients' desires for information.

Conversational strategy used by both doctors and patients to account for their behaviour was studied (Fisher & Groce, 1990). Medical interviews between doctors and patients were subjected to analysis and findings revealed that doctors controlled conversations, largely through requestions for information by which dominance was maintained. Doctors rejected accounting, but patients did not reject any account. Power asymmetry was apparent in the doctor-patient relationship.

Research demonstrated that doctors verbally controlled medical encounters by producing questions, interruptions and topic initiations (Fisher, 1984; Shapiro, Najman & Chang, 1983; West, 1984). Doctors also provided confirmations and acknowledgements in response to patients' explanations and description of the medical conditions (Stiles, Orths, Scherwitz, Hennrikus & Vallbona, 1984). Convergence was revealed in a medical consultation when efficient and accurate exchange of information was highly valued. Doctors often initiated topics of medical encounter and then both parties comprise to a particular topic (Fisher, 1984).

Health care professionals provided services that were needed and desired by patients. Conversely patients relied on advices and treatments from the health care professionals (Beisecker, 1990). Consequently, the therapist-patient relationship was footed on an asymmetry power basis, therapists possessed high power and control. The traditional health care consultation involved delivery of information by therapists, the patient's expectation and knowledge were ignored (Rodin & Janis, 1979). Health care professionals regarded themselves as experts having special knowledge. By the possession of this knowledge, the health care professionals exercised expert power.

Application of social power was examined in a hospital infection control unit (Raven, Freeman & Haley, 1982; Raven & Haley, 1982). The influence techniques utilized by infection control nurses and medical epidemiologists was measured to understand the way of getting the hospital staff to follow proper procedures in patient care regarding bases of power. Doctors were found to have tremendous expert power and used especially in influencing nurses. Expert and informational power were used by nurses who felt particularly competent. Coercive and legitimate power were used relatively more frequently by nurses who felt insecure in their position.

Social power was also frequently exercised in doctor-patient interaction. Although referent power was found to be effective in bringing about patient compliance and effective treatment, it was infrequently used by doctors (Raven & Litman-Adizes, 1986; Rodin & Janis, 1982). Expert power, on the other hand, was

one of the several sources of social power that promoted authority, and used mostly by physicians to exert social influence over their patients. In order to establish expert power, the physician displayed diplomas and degrees, as well as medical references. Doctors also talked to their patients in polysyllabic language that the patient found impressive but possibly could not understand (Raven, 1988). Another kind of social power in doctor and patient relationship, legitimate power, was based on that the patient should comply even if he or she did not have any basis for evaluating whether the recommended change was best. Other forms of legitimacy include that stemming from reciprocity or a norm of responsibility or dependency. Patients felt obligated to follow doctor's instructions for the time and effort he/she put in or patients felt powerless to deal with their problems and had to depend on them. In the present study, expert power and legitimate power were investigated to find their relationship with the language behaviour of the local physiotherapists.

2.5 Conceptual Framework

The concept of "domain" generated by Fishman (1972) has been brought forth by Li (1996) as one of the crucial factors for the language behaviour of the people in Hong Kong. Regardless of the number, domain is "a sociocultural construct abstracted from topic of communication, relationships between communicators, and locales of communication (Fishman, 1972). Similar to Li (1996), Tse (1992) also have supported the notion that code-mixing is largely domain specific, to facilitate the most convenient mode of communication between members of a social group.

Language behaviour in stable bilingual settings has been explicated in terms of domain allocation of language varieties (Fishman, 1965). The large-scale aggregative regularities and societally recognized functions, which are the indicative of the usage of varieties of language, are examined via the construct of domain.

> Domain is a sociocultural construct abstracted from topics of communication, relationship between communicators, and locales of communication, in accord with the institutions of a society and the spheres of activity of a speech community, in such a way that individual behavior and social patterns can be distinguished from each other and yet related to each other. (Fishman 1972, p. 442)

According to Fishman (1972), the language varieties in the verbal repertoire of the individuals belonging to a particular ethnolinguistic group are associated with different spheres of activity. Cooper (1969) has suggested that languages are domain specific, that is, one kind of language variety is associated with certain kind of social activities that are with values of social mobility and high culture, while the other languages each is linked to associations of intimacy and friendship. Fishman's domain of language behaviour deals with patterns of language behaviour to bridge the macrosociolinguistic and microsociolingustic approaches in terms of high-order constructs: role-relationship, topics and locales (Bolton & Luke, 1985). At the microsociolinguistic level, surveys are concerned

with particular features of language or particular linguistic items, which may be for instances, proficiency, acquisition and usage of a particular phonological and syntactic variables. Macrosociolinguistic level concerns with what languages and different varieties different group know, the order in which they learned them and how they use them are concerned.

The concept of domain is constructed to deal with an individual's language choices with reference to relative stable speech context (Fishman, 1972). The implication of topical regulation of language choice is that certain topics are on certain extent more appropriate to use one language rather than another in some particular multilingual contexts. The topic variable is crucial in understanding language choice variance. Yet the multiplicity of sources of topical regulation may not be a convenient analytic variable when language choice is considered from the point of view of the larger societal patterns and sociolinguistic norms of a bilingual or multilingual setting. Just as topical appropriateness in language choice is an indicative of larger scale societal patterns, locale appropriateness in language choice is also an indicative. While talking to the same person on the same topic but in different places, it is very often that different language choices are chosen. Very often, the university students may change instantly in their language choice for group discussion in a lecture and that in canteen on a specific topic. Role-relationship, as a component of domain, also governs language choice of bilinguals and multilinguals. Any two interlocutors within a given speech community must recognize the role-relationship that exists between them at any particular time. Role-relationships are implicitly recognized and accepted sets of

mutual rights and obligations between members of the same socio-cultural system. To describe and analyze language use or language choice in a particular multilingual setting in terms of the crucial role relations within the specific domains is considered as most revealing for that setting.

In fact, various level of analysis of sociolinguistic exists, serving different purposes (Fishman, 1976). To address the issue of who speaks what language to whom and when in those speech communities in a relatively stable bilingual and multilingual speech communities, "domain analysis of language behaviour" is a particularly useful construct for the macro-level functional description of societally patterned variation language use within large and complex speech communities. Blom and Gumperz (1972) adopted a micro-level analysis of language behaviour, they treated norms and other factors all as dimensions of one communicative system as input to a single set of rules. The emphasis was on the individual choosing among alternative modes of language behaviour in accordance with linguistic and social constraints. Fishman (1972), however, classified language behaviour in sociological terms as regularities which stand apart from individual behaviour.

To address the detailed analysis of the language behaviour of the physiotherapists in Hong Kong, we introduce a framework for conceptualizing the linguistic repertoire of communicative behaviour. The present study extends the Fishman's (1972) domain of language behaviour into health care contexts.

2.6 Objectives of the Study

Language choice is never a random choice, it is under the regularity of the linguistic repertoire of the speaker (Fishman, 1972). This study intended to construct a linguistic repertoire of the physiotherapists in Hong Kong with respect to six domains: domain with parents at home (D1); domain with siblings at home (D2); domain with colleagues in workplace (D3); domain with supervisors/boss in workplace (D4); domain with friends in a social gathering (D5); and domain with patients in a health care setting (D6). These six domains could be broadly classified into family (D1 & D2), friendship (D5) and employment (D3, D4 & D6). In health care setting, there was a dispute of power between health care professionals and their clients (Roberts, 1996). Thus, this study also investigated how the physiotherapists perceived their social power in the domain with their patients, and its relationship with language choice. The present study also ascertained a general perception of the physiotherapists on ethnolinguistic vitality and the language use.

This study made a feature of the ways the variables related to the language behaviours of the physiotherapists in Hong Kong. As changes in language use encountered by the physiotherapists in health care settings in Hong Kong was imminent, needs for further exploration in this area was feasible. The linguistic repertoire of the physiotherapists in Hong Kong would provided valuable perspectives of language situation in Hong Kong, particularly for the health care context. In brief, the three main objectives of the present study were:

1. To set up a linguistic repertoire of the physiotherapists in Hong Kong in

various domains

2. To find out any difference in perception of social power regarding different language choices.
3. To investigate any difference in perception of ethnolinguistic vitality with respect to different language choices.

Inequity of power was found in therapist-client interaction in a health care setting, and health care professionals as an influencing agent of their patients sought for social power (Raven, 1988). It was documented that the language was used to create an imbalance of power in health care setting (Spaniol & Cattaneo, 1994). Ethnolinguistic vitality of Cantonese, *Putonghua* and English in Hong Kong revealed different status among the three varieties of languages (Bolton & Kwok, 1990). English was assigned as a language of wealth, competence and intelligence. It also symbolized power and education (Cheung, 1984). Cantonese represented trustworthiness, honesty, earnestness, humility kindness, friendliness and considerateness in matched tape-recorded guises (Lyczak, Fu & Ho, 1976). *Putonghua* was assigned as another official language. Thus, a relationship between perception of social power and language use could exist. It was predicted that there would be differences in the language choices for the six domains, differences in perception of social power and perception of ethnolinguistic vitality with respect to language choice in the domain in a health care setting with patients.

Chapter Three

Method

3.1 Research Design

Language behaviour is largely domain-specific (Li, 1996). Habitual language choice is far from being a random matter. Common usage dictate that "only one of the theoretically co-available languages will be chosen by particular classes of interlocutors on particular occasions" (Fishman, 1965, p. 68). In order to systematize the manifold differences of language usage of bilinguals, domains of language behaviour organize corpus of data on language usage with regard to analytic variables: interlocutors, locales and topic. Domain is indefinite in its number, among the most prominent domains are family, friendship, education and employment demonstrated in the study of Fishman (1972).

Fishman's (1972) domain theory of language behaviour illuminated study of language usage of bilinguals from a sociolinguistic dimension, to relate specific language choice to general institutions and spheres of activity in a speech activity. Behaviour of language usage is of high complexity. It is, in fact, an interplay between linguistic, psycholinguistic, and sociolinguistic factors (Weinreich, 1953). Hamers and Blanc (1989) demonstrated that the study of language behaviour could be more fruitful by drawing other insight from various disciplines other than from the sociolinguistic dimension. They postulated that some cognitive mechanisms were activated during the interactive discourse

process. Language behaviour could be accounted for by the underlying social cognitive processes mediating between the individual's perception of the communicative situation and his communicative behaviour.

In terms of psycholinguistic dimension, language is a social instrument that reflects power used by some therapists for empowering (Spaniol & Cattaneo, 1994). Bases of power in health care contents are unequal. The general form of the therapist-client relationship exists on a spectrum of high and low control (Stewart & Roter, 1989). Physicians and other medical and paramedical professionals commonly adopt the high control style. Similarly, the physiotherapist-patient relationship is an artificial construct base on an imbalance of power. Other variables, like ethnolinguistic vitality may also enrich the psycholinguistic dimension of language behaviour (Li, 1996).

The method of triangulation was adopted. Triangulation is "the use of two or more methods of data collection in the study of some aspect of human behaviour" (Cohen & Mansion, 1994, p. 233), studying it from more than one standpoint by making use of both quantitative and qualitative data. This kind of multimethod approach is advantageous as research studies are conducted mostly in selective environment and provide limited insight with the use of unique method (Smith, 1975). Multiple method reduces considerably the chances that any consistent findings are attributable to similarities of method (Lin, 1976). It acts as a check on reliability and theory confirmation. In the present study, using triangulation allowed a deeper understanding into the language choice with

respect to various domains.

Domains were used in this study to provide view on complexity of language behaviour at which the physiotherapists interact. Six domains were selected out of the innumerable situations, and they were "domain at home with parents" (D1), "domain at home with siblings" (D2), "domain at workplace with colleagues" (D3), "domain at workplace with supervisors" (D4), "domain in a social gathering with friends" (D5) and "domain in a health care setting with patients" (D6). Most participants often encountered these domains. Like that in the study of Fishman (1972), the five domains they chose were primarily associated with family and secondarily with friendship, education, employment and religion. Yet the domain of religion was applicable in some of the cases in Hong Kong only, not as popular as that in New York city of Fishman's study. The domain of religion was, therefore, excluded from the present study.

In order to ascertain the local physiotherapists of their language use from a social psychological perspective, two psychological variables, perception of ethnolinguistic vitality and perception of social power, were examined under the social perspective in terms of domains. Knowledge about the physiotherapists on their subjective perception of their own ethnolinguistic vitality might account for their intergroup attitudes and attitudes towards language usage (Bourhis et al., 1981). The other variable, social power, might provide insight into the local physiotherapists of their perception of control and authority of their profession as well as the therapist-client relationship.

The present study was designed to inquire into the linguistic repertoire of the physiotherapists in Hong Kong, and to gather data on the perceptions of social power and ethnolinguistic vitality (Table 1). Broadly, this research study was divided into two stages. The first stage commenced with the administration of a quantitative sociolinguistic survey by the use of questionnaire. This part intended to collect a corpus of data of the language behaviour of physiotherapists in six different domains, and their general perception of social power in their profession and their perception on subjective ethnolinguistic vitality.

Table 1
The two-staged research design

Stage	Method	Scope
Stage One: Quantitative	Questionnaire	Administration of questionnaire to collect corpus of data concerning language use in different domains and perception on social power and ethnolinguistic vitality, from a sociolinguistic and psycholinguistic dimension.
Stage Two: Qualitative	Interview	Further examination of the relationships between language behaviour and the underlying social and psychological perspectives. Enquiry into unanticipated responses concerning language behaviour, and perception on social power and ethnolinguistic vitality thus giving rise to further explanation.

The second stage of the study was designed as to gain a deeper understanding of the social and psychological dimensions of the language behaviour. Semi-structured interviews were carried out upon the completion of stage one. Interviews allowed greater depth of insight into the social phenomenon of language usage by the Hong Kong physiotherapists. It acted as an explanatory

device to help identify their underlying point of view on their language choice and the opinion in terms of social power and ethnolinguistic vitality. The interviews were designed to complement the questionnaire. The interview guidelines included questions to look into the underlying causes of the phenomena of language usage and attempted to explore the role of social power exerted in the language behaviour of the local physiotherapists.

All the interviewees had been involved in stage one and had completed the questionnaire. By means of descriptive and inferential statistical analyses, the interviewees' opinions on language use were generated. Using the data as a basis, an interview guide was constructed. Interviews were then conducted, focusing on the participants' subjective experiences exposed to language usage and perception on social power and ethnolinguistic vitality. The data gathered enrich the understanding of the underpinning causes for their opinions provided in stage one, and enquiry into unanticipated responses concerning language behaviour, thus giving rise to further explanation.

The questionnaire for the study was set in English where the interviews were carried out in Cantonese. The underlying cause for the different languages used in stage one and stage two was because English was often used in writing for academic purposes and other formal situations. On the other hand, Cantonese was used for oral communication in daily activities, albeit mixed code was inserted. The interview guidelines (Appendix I) was first constructed in English, with reference to the English version of questionnaire. It was then was translated into

Chinese by a Chinese-English bilingual who had some working experiences in the profession of physiotherapy. After that, it was back-translated into English by another professional who was also a Chinese-English physiotherapist in Hong Kong.

3.2 Instrument

The design of the questionnaire was to explore the nature of language use by the physiotherapists in Hong Kong in different domains which were congruent situations to their daily life including private and public sectors. It was also designed to gather data on two variables, perception of social power and ethnolinguistic vitality.

The questionnaire was compiled from existing instruments measuring language use in different domains, perception on ethnolinguistic vitality and perception on social power. The questionnaire was a self-administered one (Appendix II). The questionnaire consisted of four sections, including a section on demographic data. The order of questions was the same for all respondents.

Section one was comprised of six questions about the language usage in six respective domains, involving primarily with family and secondarily with friendship and employment. "Domain at home with parents" (D1) and "domain at home with siblings" (D2) were two domains with relation to family. "Domains at workplace with colleagues" (D3), "domains at workplace with supervisors" (D4), and "domain in a health care setting with patients" (D6) were domains for

employment. Finally, "domain in a social gathering with friends" (D5) was a domain for friendship.

Section two contained a subscale of seventeen questions. It was used to explore participants of their opinions on subjective ethnolinguistic vitality. The original version of the 22-item scale of SVQ (Bourhis et al., 1981) was tested repeatedly and was found relatively reliable. Currie and Hogg (1994) examined the internal reliability of the SVQ and found the instrument of a high level of reliability of Cronbach alpha at .88. Labrie and Clement (1986) reported Cronbach alpha of a level at .85 and .82 for the instrument. When reported on the basis of each vitality dimension separately, Clement (1986) found the original 22-item questionnaire of Cronbach alpha ranged from .69 to .86 for each vitality dimension. Hogg and Rigoli (1996) administered the SVQ on Italian Australians of 21 Italian and 21 dialect SVQ items and found Cronbach alpha of .66 for Italian items and .73 for dialect items. After exclusion of one item the reliability was significantly improved to .81 for Italian items and .85 for dialect items.

The "subjective vitality questionnaire" (SVQ) was slightly modified for the present ethnolinguistic context. The items asking about demography in the original scale were omitted. Out of the remaining sixteen items concerning institutional support and status factors, fifteen of them were retained. Only the question about institutional support on language use in churches and places of religious worship was deleted as it might not be applicable for Hong Kong present situation. Two more questions were added to inquire the institutional support of

language use in universities and business institutions in Hong Kong. Items were answered on 5 point bipolar scales.

The next section, section three, intended to probe into participants' opinion on perception of social power. Sixteen items, based on Imai (1989) scale on social power, was used to investigate on expert power and legitimate power. Items were also answered on a five-point Likert scale. The last section gathered the participants' demographic variables, age, sex, mother tongue, education level, medium of instructions, working experiences and position held.

An interview guide was constructed with reference to the questionnaire design. Questions about language proficiency, factors for language usage in each of the domains, opinions on the existing language situation, and the language use in the present health care setting in Hong Kong were included.

3.3 Sampling

In order to examine the language use of the three language varieties, Cantonese, English and *Putonghua*, by the physiotherapists in Hong Kong, it was important that the subjects should be bilinguals. It was also essential that the subjects had experiences to encounter patients in the working environment. The criteria of the sample included were:

1. All participants should be able to read and write Chinese and English, but allowed various language proficiency.
2. All participants must be able to speak Cantonese and English, and/or

Putonghua.

3. All participants must be graduates of Diploma/BSc in Physiotherapy, and/or registered Physiotherapists.
4. All participants should at least have more than half a year of clinical experiences dealing with patients in Hong Kong.

The study was first designed to use random sampling. Random sampling was unbiased in that each selection has any more chance of being chosen than any other members (Portney & Watkin, 1993). The Hong Kong Physiotherapy Association represents most of the physiotherapists in Hong Kong and is a prestigious organization. Although it has not recruited all the physiotherapists locally, at least represent most of them. I attempted to apply for the list of membership and planned to randomly select some to their members to take part in this study. However, I was rejected by the Association with the reason that this might breach the Personal Data Privacy Ordinance and the code of practice (Appendix V). With due consideration, convenient sampling was chosen as an alternative to replace random sampling. This kind of sampling method, in statistical term, did not provide an unbiased sample selection. It was, however, a feasible way to recruit participants for this study.

Subjects (N = 61) who were invited to join the present study were experienced physiotherapists in Hong Kong. They were all able to speak English and Cantonese. Besides, they were all able to write English and Chinese. There were 29 males (47.5%) and 32 females (52.5%), age ranged from 21-45. Before

the administration of the questionnaire, they were given a covering letter with explanation of the purpose of research and the rights of refusal and informed consent.

3.4 Informed Consent

Each participant was informed consent prior to participation in this study (Appendix III). They were entitled to the rights to non-participation, the right of confidentiality, the right to remain anonymous, and the right to expect experimenter responsibility.

In order to provide subjects their right of non-participation, they obtained direct informed consent, and any non-participation and withdrawal from the study would not be entitled to any loss of benefit or penalty. They were informed that all the data were kept confidential in a locked drawer and only accessed by me and my supervisors. Explanations were given to the participants that all the data collected was only identified by a number. Participants were granted human dignity and the purpose and procedure of this study was informed and they would be able to approach me for the inquiry of this study. The rights of subjects for participants in the present study were summarized in table 2.

Table 2
The rights of participants in the present study with ethical considerations.

The right to non-participation	Directed informed consent was obtained from the participants. No loss of benefit or penalty upon withdrawal from the study.
The right to confidentiality	Subjects were informed access to their data by relevant parties only.
The right to remain anonymous	Explained to subjects that the study focused on group data and that each subject was identified by a number rather than by name.
The right to expect researcher responsibility	The purpose of the study was revealed. An offer to answer any inquiries concerning the study.

3.5 Pilot Tests

Prior to carrying out the main study, a pilot test was conducted. A panel of experts with five members was formed to evaluate the face validity of the questionnaire. Two of the panel members were experienced physiotherapists working in hospital. Another two members were academic staff of the Department of Rehabilitation Science at the Hong Kong Polytechnic University, and the final member was also academic staff at the Department of Nursing and Health Sciences at the Hong Kong Polytechnic University. Around thirty subjects were invited for the pilot test, and they were experienced physiotherapists and physiotherapy students. The participants were requested to fill out the questionnaire. The participants were first given the questionnaire about language behaviour to fill out. Fourteen days later, they were given the second questionnaire, which was the same version as the first questionnaire to fill out.

The questionnaire was reliable, and test-retest reliability yielded coefficients ranging from $\underline{r} = 0.81$ to $\underline{r} = 0.90$. The internal consistency for section two and section three were also acceptable, with an alpha coefficient of .94 and .76 respectively.

Six questions inquiring into the respondents' reasons for choosing a specific language in each of the six domains were deleted from the questionnaire. Instead, the six questions for investigating their language use in the six domains were examined in the in-depth interviews.

Chapter Four

Results and Data Analysis

4.1 Demographic Data

Data showed that among the 61 participants (n for male = 29; n for female = 32), there were 33 Physiotherapists II (54.1%), 24 Physiotherapists I (39.3%), 1 Senior Physiotherapist (1.6%) and 3 Department Managers (4.9%), where Physiotherapist II had the lowest rank and Department Manager had the highest. None of the participants was student or had the rank higher than Department Manager. Their age ranged from 21 to 45. Six out of the 61 participants (9.8%) had more than 16 years of working experience in the field of physiotherapy, 3 participants (4.9%) had 11 to 15 years of working experience, 22 participants (36.1%) had 5 to 10 years of working experience and 30 participants (49.2%) had less than 5 years of working experience. The education level of the participants ranged from Professional Diploma to Master Degree. There were 20 Professional Diploma holders (32.7%), 30 Bachelor Degree holders (49.2%), 7 Postgraduate Diploma holders (11.5%), and 4 Master Degree holders (6.6%).

The medium of instruction of the participants' secondary schools was mainly bilingual, Chinese and English, 53 out of 61participants (86.9%) received bilingual education. Others participants received education in either pure Chinese or pure English, 3.3 % were educated in Chinese, and 9.8% were in English. With regard to their mother tongue, there was an overwhelming proportion of native

Cantonese speakers. Sixty of them (98.4%) used Cantonese as their mother tongue and the remaining participant (1.6%) used *Putonghua*. The demographic data of the participants was summarized in table 3.

Table 3
The distribution of demographic data of the 61 participants

Demographic Data		Frequency	Percentage (%)
Gender	Male	29	47.5
	Female	32	52.5
Age	21-25	20	32.8
	26-30	23	37.7
	31-35	11	18.1
	36-40	6	9.8
	41-45	1	1.6
Mother tongue	Cantonese	60	98.4
	English	0	0
	Putonghua	1	1.6
Medium of instruction of secondary school	Chinese only	2	3.3
	English only	6	9.8
	Chinese and English	53	86.9
Education Level	Professional Diploma	20	32.7
	Bachelor Degree	30	49.2
	Postgraduate	7	11.5
	Diploma	4	6.6
	Master Degree		
Position	Physiotherapist II	33	54.1
	Physiotherapist I	24	39.3
	Senior	1	1.6
	Physiotherapist	3	4.9
	Department Manger		
Years of Working Experience	Less than 5 years	30	49.2
	5-10 years	22	36.1
	11-15 years	3	4.9
	More than 16 years	6	9.8

4.2 Language Use in Different Domains

The language choices of the physiotherapists in Hong Kong were collected with respect to six domains. Data showed that Cantonese, and mixing of Cantonese and English were the most common languages chosen to use by the local physiotherapists in the six domains.

Domain at home with parents (D1)

When the participants talked to their parents at home, 50 out of 61 (82%) chose Cantonese. In this domain, the second most commonly used language was mixing of Cantonese and English, 6 of them (9.8%) chose it. Other participants chose mixing of Cantonese and *Putonghua* and mixing of Cantonese, English and *Putonghua*, each was 1.6% of the population.

Domain at home with siblings (D2)

In this domain, the number of participants used Cantonese, mixing of Cantonese and English were 29 (47.5%) and 21 (34.4%) respectively. The proportion of participants chose mixing of Cantonese and English was relatively higher than that in D1. It was about three-folded of the number of participants using mixing of Cantonese and English in the domain with siblings than that with parents, although the majority still used Cantonese.

Domain in a workplace with colleagues (D3)

In the domain of a workplace with colleagues, comparatively more participants used mixing of Cantonese and English than those who used Cantonese.

There were 8 participants (13.1%) chose Cantonese and 53 (86.9%) chose mixing of Cantonese and English. Unlike those in D1 and D2, the majority of the participants used mixing of Cantonese and English , but not Cantonese.

Domain in workplace with supervisors or boss (D4)

Similar to D3, most of the participants used mixing of Cantonese and English in this domain. The number of participants used Cantonese, mixing of Cantonese and English, and mixing of *Putonghua* and English, was 8, 51 and 1 respectively. The respective percentage were 13.1%, 83.6%, and 1.6%.

Domain in a social gathering with friends (D5)

When the participants talked to their friends in a social gathering, 20 (32.8%) used Cantonese and 37 (60.7%) used mixing of Cantonese and English. Two of them (3.3%) used mixing of Cantonese, English and *Putonghua*. Only 1 (1.6%) participant used *Putonghua*.

Domain in a health care setting with patients (D6)

In this domain, there were 37 participants (60.7%) of the participants used Cantonese to communicate with their patients. It was a comparatively higher percentage than that in D3 and D4. Fourteen of them (23.0%) used mixing of Cantonese and English, and 6 (9.8%) used mixing of Cantonese, English and *Putonghua*.

Table 4
Language usage in various domains selected by bilinguals

Varieties of languages	Domains					
	D1	D2	D3	D4	D5	D6
Cantonese	82%	47.5%	13.1%	13.1%	32.8%	60.7%
English	_	_	_	_	_	_
Putonghua	_	_	_	_	1.6%	_
Mixing of Cantonese & English	9.8%	34.4%	86.9%	83.6%	60.7%	23%
Mixing of Cantonese & *Putonghua*	1.6%	_	_	_	_	_
Mixing of *Putonghua* and English	_	_	_	1.6%	_	_
Mixing of Cantonese English & *Putonghua*	1.6%	_	_	_	3.3%	9.8%
Others	4.9%	18%	_	_	1.6%	6.5%

D1 = Domain at home with parents;
D2 = Domain at home with siblings;
D3 = Domain in a workplace with colleagues;
D4 = Domain in workplace with supervisors or boss;
D5 = Domain in a social gathering with friends;
D6 = Domain in a health care setting with patients

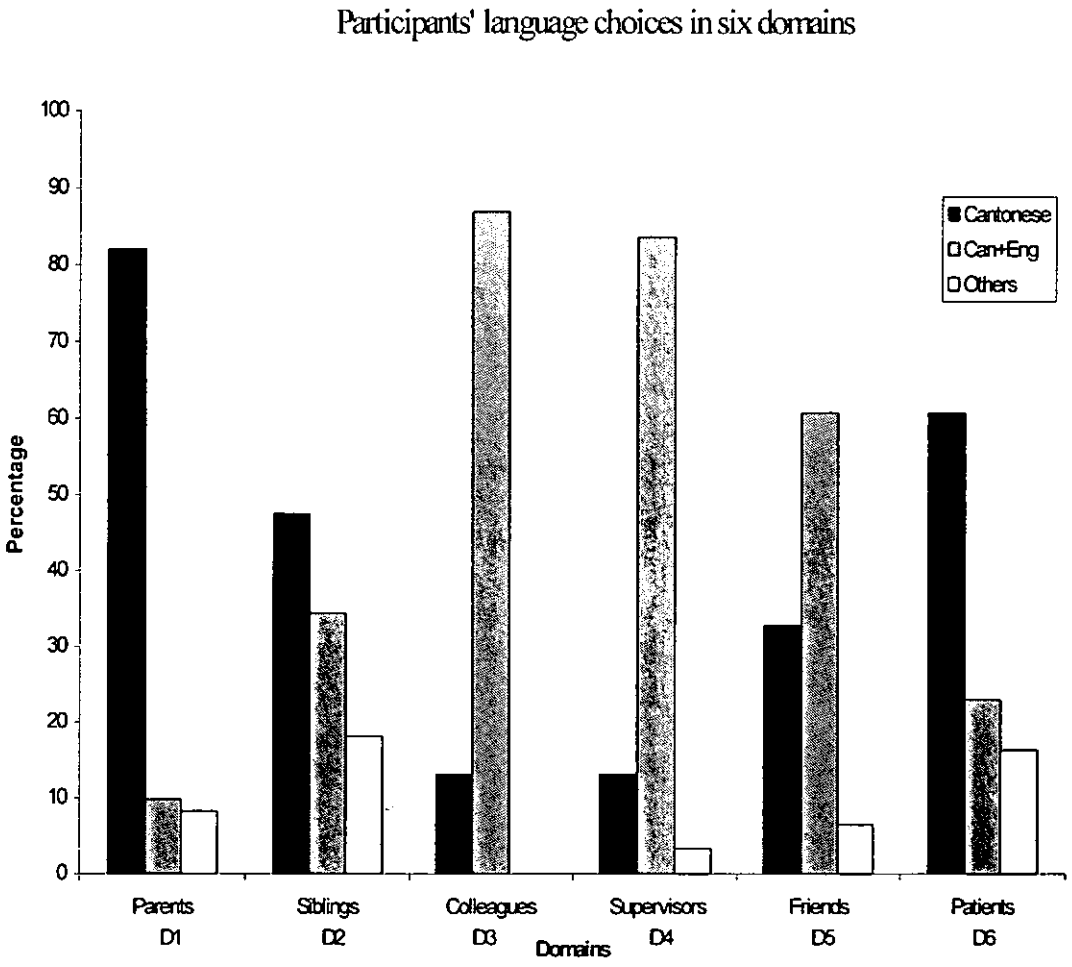

Figure 1. Distribution of language choices in the six domains among the pariticipants

4.3 Ethnolinguistic Vitality and Language Use

The data of the subjects' perception on ethnolinguistic vitality were analyzed with reference to status factors and institutional support factors, and then an overall analysis on subjective ethnolinguistic vitality.

With regard to the language status in Hong Kong, Cantonese was the most highly regarded (M = 4.36, SD = .75), followed by mixing of Cantonese and English (M = 4.21, SD = .71), English (M = 3.82, SD = .65), *Putonghua* (M = 2.87, SD = .76), mixing of Cantonese and *Putonghua* (M = 2.80, SD = .93), mixing of Cantonese, English and *Putonghua* (M = 2.79, SD = 1.11), and mixing of *Putonghua* and English was the least highly regarded (M = 2.49, SD = .99). English was most highly regarded internationally (M = 4.75, SD = .43), followed by *Putonghua* (M = 3.37, SD = .76), and Cantonese was the least highly regarded internationally (M = 2.48, SD = .93). The results were summarized in table 5.

People of Chinese descent who spoke mixing of Cantonese and English were most highly regarded (M = 3.87, SD = .78), followed by people of Chinese descent who spoke English (M = 3.41, SD = .92), and then was people of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M = 3.33, SD = 1.13). The least highly regarded group was people of Chinese descent who spoke *Putonghua*, where M = 2.82, SD = .74.

Table 5
The different status of languages, Cantonese, English, *Putonghua* and mixed code, in Hong Kong and internationally

Language/dialect	How highly regarded			
	In Hong Kong		Internationally	
	M	SD	M	SD
Cantonese	4.36	.75	2.84	.93
English	3.82	.65	4.75	.43
Putonghua	2.87	.76	3.37	.76
Mixing of Cantonese and English	4.21	.71	_	_
Mixing of Cantonese and *Putonghua*	2.80	.93	_	_
Mixing of English and *Putonghua*	2.49	.99	_	_
Mixing of Cantonese, English and *Putonghua*	2.79	1.11	_	_

People of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* were most proud of cultural history and achievement (M = 3.70, SD = .84), then were the groups of people of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M = 3.61, SD = .99), and people of Chinese descent who spoke English (M = 3.49, SD = .87). The least were people of Chinese descent who spoke *Putonghua* (M = 3.05, SD = .85).

In terms of wealthiness, it was found that people of Chinese descent who spoke mixing of Cantonese and English (M = 3.89, SD = .71) and people of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M =

3.89, SD = .88) were perceived as most wealthy. People of Chinese descent who spoke English (M = 3.82, SD = .59) was perceived as the group as the second most wealthy. People of Chinese descent who spoke *Putonghua* were perceived as least wealthy (M = 3.16, SD = .78)

In Hong Kong government services, the three most often used languages were mixing of Cantonese and English (M = 4.20, SD = .75), Cantonese (M = 4.13, SD = .67), and English (M =3.97, SD = .73). Mixing of *Putonghua* and English was the most seldomly used.

Regarding the control over economic and business matters in Hong Kong, people of Chinese descent who spoke mixing of Cantonese and English had greatest control (M = 3.92, SD = .74), followed by Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M = 3.57, SD = 1.02), and English speaking people of Chinese descent (M = 3.38, SD = .90). The people of Chinese descent who spoke *Putonghua* had the least control (M = 2.97, SD = .82).

With regard to well-representativeness of the languages in Hong Kong mass media, the most well-represented language in mass media were Cantonese (M = 4.36, SD = .80), English (M = 4.10, SD = .68) and mixing of Cantonese and English (M = 3.64, SD = 1.14), and the least well-represented was mixing of *Putonghua* and English (M = 2.44, SD = .81).

Chinese (M = 3.95, SD = .80) was taught more often in schools in Hong Kong than English (M = 3.87, SD = .64), while English (M = 2.57, SD = .94) was taught more often in universities in Hong Kong than Chinese (M = 4.18, SD = .87).

For the possess of political power, people of Chinese descent who spoke mixing of Cantonese and English were perceived to have the greatest political power (M = 3.89, SD = .75), and then were people of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M = 3.75, SD = 1.07), followed by people of Chinese descent who spoke English (M = 3.41, SD = .80). People of Chinese descent who spoke Cantonese were perceived to have the least political power.

In business institutes, English (M = 4.07, SD = .63), mixing of Cantonese and English (M = 3.95, SD = .76), and Cantonese (M = 3.64) were the most well-represented spoken language, while mixing of *Putonghua* and English (M = 3.15) was the least. For written languages, English (M = 4.33) was more well-represented than Chinese (M = 3.13) in business institutes.

Regarding cultural life, people of Chinese descent who spoke Cantonese were most well-represented in cultural life (M = 3.75), then were people of Chinese descent who spoke mixing of Cantonese and English (M = 3.62) and people of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M = 3.36). The least were people of Chinese descent who spoke *Putonghua* (M = 2.77).

sOverall Vitality

People of Chinese descent who spoke mixing of Cantonese and English (M = 4.13) were perceived to be the strongest and most active group in Hong Kong. The second strongest and most active group were people of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M = 3.75), followed by people of Chinese descent who spoke Cantonese (M = 3.66). For 20 to 30 years later, the people of Chinese descent who spoke mixing of Cantonese, English and *Putonghua* (M = 4.21) would be the strongest and most active group in Hong Kong, followed by people of Chinese descent who spoke mixing of Cantonese and English (M = 3.75), and people of Chinese descent who spoke mixing of Cantonese and *Putonghua* (M = 3.59).

It was found that there was little contact between people of Chinese descent who spoke *Putonghua* and people of Chinese descent who spoke English (M = 2.66), but more contact between people of Chinese descent who spoke Cantonese and people of Chinese descent who speak English (M=2.82), and even more between people of Chinese descent who spoke Cantonese and people of Chinese descent who spoke *Putonghua* (M = 3.11),

An independent t-test revealed there was no significant difference in perception of ethnolinguistic vitality for groups with language choices of Cantonese and mixing of Cantonese and English in the domain in a health care setting with patients ($t = .713$. $p > .05$).

4.4 Social Power and Language Use

The mean value of social power was 28.77 ($\underline{M}$ = 28.77, $\underline{SD}$ = 4.43). The mean value of expert power was ($\underline{M}$ = 15.10, $\underline{SD}$ = 2.71), while the mean value of legitimate power was ($\underline{M}$ = 13.67, $\underline{SD}$ = 2.76).

An independent sample t-test showed that there was no significant difference in the perception of social power between groups with language choices of Cantonese and mixing of Cantonese and English in the domain in a health care setting with patients ($t = .775$. $p > .05$).

4.5 Summary on Interviews

The purpose of interview was to gain a deeper understanding of the physiotherapists' opinions on language use, their perception on social power in health care setting, and therapist-client relationships.

When ascertaining into reasons of using of Cantonese by the interviewee, four major areas were identified. Cantonese was used as a common language for people in Hong Kong, better expression, better understanding by interlocutors, and for the purpose of ethnic affirmation.

A majority of people in Hong Kong used Cantonese, an interviewee explained that "... I have been it (Cantonese) using for years, and all the people here use Cantonese. I can express myself most when using it... (Case 1, p. 151)".

She further explained that "... I am a native Cantonese speaker, and most people around are also using Cantonese, it's is natural to use it..." (Case 1, p. 151). Another interviewee also stated that "... most people in Hong Kong their mother tongue is Cantonese..." (Case 2, p.159). On the other hand, Cantonese was also used for better communication. As an interviewee suggested that "it's easiest to express yourself..." (Case 1, p. 151). One interviewee used Cantonese when the person she talked to was a monolingual Cantonese speaker. "If everybody knows Cantonese, and they could not understand other languages, I will probably use Cantonese..." (Case 3, p. 168). Similarly, Cantonese was used so that "we understand each other" (Case 2, p. 159). Using Cantonese for ethnicity solidarity was stated by an interviewee "... as we are Chinese, when you say something, you should be able to use your own language..." (Case 4, p. 179). Other reasons for using Cantonese was that their family members didn't understand other languages.

For using English, it was attributed to four main reasons, communication with native English speakers, avoiding disclosure of information to patients, conformity to doctors, and professionalism. One of the interviewees revealed that English was used "... therapists usually English when talking in front of patients. It's a kind of professionalism. Of course, when talking to a foreigner, you have to use English." (Case 2, p. 159). It was also stated by an interviewee that "when discussing the case with my colleagues, and we don't want the patient to know anything about it, then we may use English." (Case 1, p.151). Moreover, "when talking about patients' conditions or some of the subjective feelings" (Case 4, p. 178). Conformity to doctors was indicated by an interviewee, "the Senior Medical

Officers speak to you in English, we thus have to speak English" (Case 1, p.151).

Putonghua, however, was not used so often by some of the interviewees. One of the interviewees even claimed to have little knowledge in Putonghua. Rarely was it used as a language for communication "if the patient does not know any other kind of languages" (Case 4, p. 178). Mixing of Cantonese and English, on the contrary, was used mainly due to its commonality in Hong Kong, or it was used when no equivalent of English terms in Chinese. According to one interviewee, "nowadays many people here know Chinese and English....it's a trend....some of the terms in English allows much better understanding..." (Case 1, p. 152). Another interviewee said that "while having been learning in English, I can't even think of the terms in Chinese..." (Case 2, p. 159). Other interviewees revealed that "many of the terms you've learned in secondary schools are in English....I don't know the terms in Chinese" (Case 2, p. 160), and "English will be used only when I don't know the terms in Chinese" (Case 4, p. 178).

All the interviewees agreed that communication was important in health care consultation. When asking about any difficulties they met in the communication with their clients, interviewees consistently mentioned about the present chaotic language situation in Hong Kong. According to an interviewee, "all the health care professionals learn in English....and there are around 90% of the clients speak Cantonese. It's conflicting to talk to patients in Chinese but learn them in English..." (Case 1, p.155). Also it was indicated that "the physiotherapy students learn in English....They may have difficulty in expression....But when

all the stuff are taught in Chinese, they may have problems for communication internationally" (Case 4, p. 180). Some interviewee had experiences in communication breakdown that "some of the elder women speak Fukien... There must be someone to translate for me!" (Case 3, p. 174), or "... I can't understand patients who speak Hakka, Shanghainese and so on. The patients also can't understand Cantonese" (Case 4, p. 181).

The participants' perception of social power were studied. Generally, it was found that the perception of social power among the local physiotherapists were not high. As one interviewee indicated that "... we don't have much autonomy....Doctors order you to give partial weight....Sometimes you don't think the patient need physiotherapy anymore, but the doctor insists, you have to continue..." (Case 4, p. 182-183). According to one interviewee "... we don't have much social power... with such a smaller number of physiotherapists in Hong Kong, the status is relatively low" (Case 3, p. 175). Suggested by another interviewee, "in hospital, doctors are dominant.... Sometimes maybe I want to discharge patients, but they request continuation of treatment, then we have to follow..." (Case 1, p. 157). Relations between perception of social power and language use were also examined. Language was commonly not used as a strategy for dispute of power between the local physiotherapists therapists and their clients. It was revealed by interviewees that "I don't think speaking a specific type of language can change your social power" (Case 4, p. 183), and "I think it depends on whether you really have that kind of power or not" (Case 1, p. 157).

All in all, the interviews provided invaluable insight into the local physiotherapists of their opinion on the language use in Hong Kong, and also their point of view of its relation to social power. It was, however, none of the interviewees suggested that their social power in a therapist-client relationship could be manipulated by language use.

Chapter Five

Discussion

5.1 Theoretical Implications

The present study is an empirical attempt to study language behaviour of the physiotherapists in Hong Kong. It intends to explore their language use among the wide range of language choices available, with respect to a social psychological perspective. The notions of social power and ethnolinguistic vitality are examined in order to explore their role underlying language use. Findings from the present study establish a linguistic repertoire for the local physiotherapists with respect to six domains, which is primarily vital for a basic understanding of the chaotic language situation for both sentimental as well as instrumental language use. Contrary to previous studies, results in this study demonstrate that the role of social power and ethnolinguistic vitality is negligible in this particular language situation in Hong Kong.

There are several interesting findings from the present study deserve in-depth discussion. First, there are variations in language choice among the local physiotherapists with different interlocutors and locules. Second, social power is showed to be trivial in exerting effects on language use, even though conversational strategies are commonly used as a dispute for power in therapist-client relationship in a health care context. Third, the perception of ethnolinguistic vitality is also insignificant in its role for the variation of language choice.

Language use in Hong Kong outside education contexts has not been studied much. A few studies have preliminarily shown that the pattern of language use in employment parallels in some degree with that in education. Poon (1992) found that uses of spoken and especially written English were widespread among the senior accountants and company administrators in Hong Kong. Among those respondents, over 95 per cent reported "often", "very often" or "always" for written communication, where over 80 per cent reported English as their usual tool for oral communication. The proportion of people using spoken English in the domains of employment in the present study is not as common as those in that study. None of the participant uses pure English in speech frequently.

Yet, the present study supports the findings from the study of Luke and Richards (1982) that English is essential for reports writing, even though it is not commonly used for spoken language. The study about language use in Hong Kong conducted by Luke and Richards (1982) observed differential needs for English language in different business and commercial sectors. They observed that a Chinese-speaking medical doctor would normally talk to patients in Cantonese but took records and gave prescriptions in English. Consultations by doctors, psychiatrists, and social workers were conducted in Cantonese, but the written reports were prepared in English. The respondents in the present study used English in situations only when they talked to their colleagues in health care settings where patients were also present, and when they talked to native English speakers. It is understandable that the respondents use English when they talk to

monolingual native English speakers. But further insight has to be gained to understand why the respondents use English when they talk to senior medical officers.

The present study also confirms that English symbolizes higher education, and serves as one of official languages for communication in government and academic institutions, while Cantonese is used mainly in informal and intimate situation (Cheung, 1984; Gibbon, 1982). For the domain at home with parents, 82% of the participants talk to their parents in Cantonese. It substantiates the use of Cantonese as the symbolic of intimacy and solidarity.

Another reason for the predominant use of Cantonese is due to the low education level of the parents of the participants. In the domain at home with siblings, 47.5 % of the participants use Cantonese, higher than in percentage than those using mixing of Cantonese and English by 13.1%. The reasons may be due to that the education level of their siblings might probably higher than their parents. The distribution of proportion of speakers in each of the varieties of languages in D1 is a miniature of the overwhelming Cantonese speakers in Hong Kong. According to the Census and Statistics Department (1996a, 1996b), Cantonese is the most common language spoken at home, of 88.7 per cent of the Hong Kong population, and Cantonese acts as the *lingua franca* for the majority of people in Hong Kong (Pennington, 1994b). The results of this study reflect that the participants are similar to the general population as revealed from the Census and Statistics Department (1996a, 1996b) in Hong Kong.

In the domain with friends, mixing of Cantonese and English is more often used (60.7%). "To some extent, code-mixing is a sign of membershipping [sic], the use of English lexical items marking group membership" (Luke & Richards, 1982, p. 57). The overview of the motives of code-mixing provided by Tse (1992) may explain the use of mixing of Cantonese and English in this domain. This kind of vernacular is used so as to accommodate to the listeners and for identity-maintenance. It is also needed for certain English expressions to communicate. In addition, it is used for the purpose to impress others, and to show linguistic proficiency and social status. As indicated by many interviewees, mixing of Cantonese and English is to express a meaning which cannot be fully conveyed in Cantonese.

In the domain of a health care setting, 60.7% of the participants use Cantonese to communicate with their patients. It is a comparatively higher percentage when compared with those who use Cantonese in the domains of workplace with colleagues or boss. It reveals accommodation in health care context. It may due to the recognition of the importance of communicating effectively, exchanging information accurately and fostering rapport (Street, 1991). As the key to success in a health care consultation is verbal communication (Ong et al., 1995; VanCott, 1993), the physiotherapists in Hong Kong have to use the language that most of their clients can understand. Due to the fact that the majority of the people in Hong Kong are Cantonese speakers, Cantonese is necessary to use for effective communication.

Mixing of Cantonese and English has been neglected for its uses, but several studies have already shown its increasing use in Hong Kong. Tse (1992) found "in informal conversation, code-mixing between Cantonese and English is almost ubiquitous in Hong Kong, with Cantonese being the dominant code" (pp. 101-102). Chan (1993a, 1993b) documented spoken code-mixing in Hong Kong from various sources, including discussion sessions of tutorials at the Chinese University of Hong Kong, informal conversations, television and radio interviews and phone-in conversations. There were 78.8% of the cases involved minimal one word insertions of mixed code, 21.2% involved multi-word insertion switches of two or more English lexicons. In the present study, all the six domains have documented uses of mixed code of Cantonese and English, vary from the lowest of 9.8% in D1 to the highest of 86.9% in D3. In addition to the pattern of usage of code-mixing in causal discussion of academic topics as documented by Gibbons (1979a, 1979b, 1983, 1987), and in many other domains of modernity as in "computer discourse", "business discourse", "fashion discourse" and "showbiz discourse" demonstrated by Li (1996), the present study indicates that it is also used for specialized technical terms.

As a result of the functional differentiation of Cantonese, English and *Putonghua* in Hong Kong and the social differentiation of each group of the speakers, use of a particular variety of languages in a particular domain will be socially significant. When selecting a distinct language variety to use, either consciously or unconsciously, a particular sign of membership is indicated

(Pennington, 1994b). The relationship between language and culture has been recognized in anthropology and linguistics. Kwok et al. (1972) noted that the culture of many young people in Hong Kong was neither totally Chinese nor totally Western, but a mixing of Chinese and Western culture, which was expressed by the mixture of Chinese and English. Lord and T'sou (1985) described that students in Hong Kong were facing "cultural eunuch" as they were learning English in cultural terms but not able to participate. They noted that cultural eunuch was "brought about by the encrustation of a light veneer of western culture, glimpsed through exposure to the English language in schools and the media, on to a less than wholesome body of Chinese and culture" (p. 17). It is particularly true in the health care settings. The physiotherapists in Hong Kong may try to maintain their Chinese ethnic identity, but are exposed to western culture.

Luke and Richards (1982) described the English and Cantonese speaking groups in Hong Kong as separate communities, but bridged together in certain extent. Mixed code symbolizes sociocultural mixing between native English speakers and native Chinese speakers, and less dominance of native English speakers over native speakers (Gibbon, 1984). When communicating for private functions, the choice is Cantonese. In the domains at home, it is always the mother tongue being chosen. It is supported by the study of Fishman (1972) conducted in Puerto Rican in Jersey City. Data showed that mother tongue was used particularly with parents. The pattern of language use is functionally motivated, which involves frequent switching between codes, to aid understanding. When

aimed for certain academic goals English is replaced by a more macro pattern of situational code-switching, in which each code choice is strongly associated with particular settings, participants, and roles in a more tightly bound alignment of value cluster and situational features.

The present chaotic language situation in Hong Kong has already pertained into health care context. English and Chinese has been legislated as the official languages in Hong Kong. But English is still perceived as the language of success (Lau, 1991), and used in government, education and business. The Chinese language has its status as an other official language since 1974, for less than 30 years. At present, English is still the medium of instruction for more than half of the secondary and tertiary education institutes in Hong Kong. Due to the inherent ambiguity of the word Chinese, it is still confusing where referring to the Chinese language (Pierson, 1994). Chinese includes Cantonese, *Putonghua* and other Chinese dialects, as well as the standard written Chinese and the classic written Chinese. Cantonese is the vernacular of Hong Kong, but which is not socially prestigious as *Putonghua*, where it is the *lingua franca* of Mainland China and Taiwan.

Language use has been identified as a marker for social power (Thimm & Kruse, 1993). In their study, the verbal production of spontaneous emotional expressions by the participants, who were female college students, depended on status differences of their interactional partner. In unequal status situation, less self-disclosing topics were more typical, whereas in equal status condition, student

talk, personal topics, and direct and indirect signals of affective states were more common. Social power inequities in some groups and processes are reflected in language (Johnston, 1993). Studies of the therapist-patient relationship uniformly describe an asymmetry of knowledge and authority that allows therapists to promulgate a biomedical model of disease, and advance their professional dominance (Maynard, 1991). Therapists in health care context have the power to disseminate medical expertise at the expense of lay forms of understanding. The reciprocal exchange of treatment-related information in a consultation improves patient compliance, based in part on how well the patient understands what the therapist is saying (Rost, Carter & Inui, 1989). Therapists have been called for decades to adapt their language to the patient's level, but few know precisely how basic that level is, and "communication is....pervasively taken for granted" (Pettegrew & Logan, 1987, p. 676).

An important determinant on the use of health care services by ethnic minority groups is language issue. In the study of Boult and Boult (1995), Asian-Americans (21.8%) in the United States were more likely than the whites (6.2%) to have visited doctors infrequently. Immigrants often experience difficulty with the English language, which isolated them from health care services seeking, where western medical care was usually provided in English by practitioners who knew little about Asian's culture and their languages. In Australia, the proportion of the Australian population from non-English-speaking backgrounds is increasing, but this group is proportionately lower in the use of health services and institutions than that of other Australians, and many services for a family member

with a disability or illness at home (Plunkett & Quine, 1996). The experiences of the carers for this group of people in using health and other support services was documented, and found that underutilisation was specifically related to English language deficits and cultural differences.

In the health care context, even though Hong Kong is an ethnically homogenous society, with less than 2 per cent are non-Chinese, predicaments in language use may be generated (Hirvela, 1991; So, 1987). Cantonese is the usual language spoken by about 89 per cent of people in Hong Kong (Census & Statistics Department, 1996a, 199b). But most of the health care professionals in Hong Kong are educated in English. With the influx of immigrants mainly from Mainland China, and some of them are monolingual *Putonghua* speakers. With only about one-third of people in Hong Kong speak *Putonghua* as a usual language or as another language, difficulties in their communication may be generated.

Paucity of research has documented the health care professionals in Hong Kong of their knowledge in *Putonghua*. Besides, little research has examined the use of health care services by the monolingual non-Cantonese-speaking and monolingual non-English speaking groups in Hong Kong. As the present study is designed mainly to examine the language use by the local physiotherapists in health care context under the psychological factor of perception of social power, an imminent need for deeper understanding on this issue calls for further studies.

Contrary to previous studies, social power does not have any significant relationship with language use by the local physiotherapists. Cantonese is mainly chosen as the language for communication with their clients. One of the reasons may be due to communication accommodation of the physiotherapists to their clients. According to the communication accommodation theory (CAT), interactants have motivations for adapting their communication relative to their perceptions styles of the interlocutors, and interactants form impressions and evaluations of partners with respect to their expectations for a partner's communicative styles relative to their own style (Giles et al., 1991). The local physiotherapists may target at the goal of mutual understanding of the information in a health care consultation, and use the language of which the client could understand most. When asking the physiotherapists which language would be the most feasible one for communication with their clients, Cantonese has been chosen as the most suitable one because patients could understand most. The participants regarded that most colleagues would find Cantonese let them express themselves most easily.

Another physiotherapist interviewed has pointed out that the language chosen to be used to communicate with their clients should be the one they could easily understand.

> It would be better if you could speak different varieties of languages, so that whenever different kind of patients come in, you speak the language they prefer most....and misunderstanding can be avoided....If the patient speak fluent Cantonese, I would use Cantonese. But when they are not fluent at all, I would prefer talking with them using other languages, either *Putonghua* or English. (Case 3, p. 173).

When both parties, the therapist and the client, recognize the importance of effective communication, then therapists-client interactions may reveal convergence among behaviours representing affiliation and involvement in the interaction (Street, 1991). Services provided by the local physiotherapists are in the form of "person-centered" approach. Verbal communication with their clients is an indispensable tool to obtain information critical to diagnosis and treatment. The language chosen by the local physiotherapists to use is the one that promotes patients' understanding, and allows their clients to express their needs, attitudes and feelings. But one point has to be pinpointed is that with the limited number of physiotherapists in Hong Kong who have fluency in *Putonghua*, *Putonghua* speaking patients as a minority group may not be provided with the conditions for efficient communication with their therapists.

The use of Cantonese predominantly in the health care domain may also be postulated by the highly perceived vitality of the people in Hong Kong. With regard to the language status in Hong Kong, Cantonese are the most highly regarded. Cantonese-speaking people affirm their Chinese identity through their mother tongue, Cantonese (Pierson, 1992). Traditionally, the Cantonese have considered themselves a distinctive subgroup in China, Cantonese are naturally proud of being Chinese, they are equally proud of just being Cantonese (Pierson, 1994; Wilson, 1990). *Putonghua* is minimally used in Hong Kong, and Cantonese is spoken in those areas of South China and preserve in the domains of friendship and family (Li, 1988). One of the possible factors for the tenacious hold of Cantonese in Hong Kong may be due to colonial rule by British. It is revealed from the data that the group of Chinese descents in Hong Kong speak mixing of English and Cantonese are most highly regarded. They are also regarded as most wealthy, having greatest political power, and are the strongest and most active group in Hong Kong. The group of Chinese descents who speak *Putonghua*, however, are the least highly regarded.

The physiotherapists in Hong Kong are predominantly educated in a bilingual mode in secondary schools. There are some discrepancies between the figures of language use in the study of Johnson (1991) and the present study. Johnson compared the use of languages in the secondary schools at that time with the figures in 1981. He has found a decrease in the use of English, but an increasing use of Cantonese and English mixed code and Cantonese. In his study, the use of English has been decreased from 43% to 15%, but the use of Cantonese

increased from 48% to 65%, while mixing of Cantonese and English increased from 9% to 20%. The reason for that may be due to the fact this study has only included the questions inquiring into the participants' medium of instruction in schools as a reference and simply gathered their language of education into Chinese and English. But in Johnson's study, the main purpose was to investigate the language use in secondary schools, and they intensively divided the code choice into Cantonese, English and *Putonghua*.

The predominant Chinese-English education laid the clue to the use of mixing of Cantonese and English in some of the domains. In his study, Johnson reported that the use of Cantonese with embedded English terminology as the dominant mode in subjects of Science and Mathematics in forms 6 and 7. It is compatible with the findings in this study in the domain in a workplace with colleagues and in the domain in a workplace with supervisors and boss. As the two domains are work-related, it may inevitably have to use technical terminologies.

The influence of the English language in Hong Kong is manifested in the use of language in government and education. Cantonese people are proud in their ethnic identity but recognize the reality that English is highly regarded internationally (Pierson, 1994). But there is speculation that English will be replaced by *Putonghua* as the "language of success" (Lau, 1991).

The results of this study indicate that with regard to the language status in Hong Kong, Cantonese is the most highly regarded. English is, however, the most highly regarded internationally, and Cantonese is the least highly regarded internationally. It shows that people in Hong Kong are high in their ethnic identity as Cantonese. The census has never taken mixing of Cantonese and English into account as a language, but the results reveal it is ubiquitous and is perceived as a language of high status. The English language is banned for intra-ethnic communication (Li, 1996). But people in Hong Kong recognize the fact that it is highly regarded internationally and is vital for business, mixed code thus is appeared to express the dual code functions.

The settings in each speech community differ from each other in so many ways that every researcher on communication need to grapple with the problem of how to systematize and organize the manifold differences that has been recognized. The concept of domains of language behaviour (Fishman, 1972) is adopted in the present study. Domain helps organize and clarify previously unstructured awareness on language. Habitual language choice is far from being a random matter, and only one of the theoretically coexist languages or varieties is chosen by a particular group of interlocutors in a specific situation for the discussion on particular kind of topic. A domain is an abstract set of relationships between status, topic and locale and gives meaning. We may have more than one social status, and this gives a person the opportunity to manipulate a situation, and to invoke relationship with the interlocutor not necessarily most relevant to the particular domain. By that, it allows changing role-relationship other than the one is

primarily defined, with the use of language (Breitborde, 1983).

The concept of domains of language behaviour represents an attempt to provide socio-cultural organization and socio-cultural context for considerations of variance in language in multilingual settings. When systematically interrelated with other source of variance in language behaviour and when based upon underlying analyses of the role-relations and topics most crucial to them, domains of language behaviour may contribute importantly to the establishment of dominance configuration summaries. Domain analysis may be a promising conceptual and methodological tool for future studies of language behaviour in multilingual settings and for socio-linguistic studies more generally. Ultimately, a relatively uniform but flexible analytic scheme may enable us to arrive at valid generalizations concerning the kinds of multilingual settings in which one or another configuration of variance in language choice obtains, and language maintenance or language shift consequences of particular configurations of dominance or variance.

Sociolinguistics serves mainly for explaining various phenomena concerning linguistics with regard to social system (Chen & Chen, 1990). This study take a social and psychological approach which allows studying language behaviour in a framework of social and psychological constructs. Blom and Gumperz (1972) introduced a microlinguistic level of analysis of language behaviour. They employed the methods of participant observation and analysis of spontaneous speech to detect linguistic and social constrain on language use. This

level of analysis provided a detailed study of individual language behaviour. It, however, lacked an explanatory power of social organization (Breitborde, 1983). The macro-level of analysis language behaviour by Fishman (1972) is adopted in this study. The key concept of his study is the notion of "domain" (Fishman, 1972), characterized by topic, locale and role-relationship of interlocutors. Macrosociolinguistics helps understanding of language behaviour relating to social system.

5.2 Clinical and Educational Implications

In clinical settings, mixed code of Cantonese and English is used more frequently when talking to colleagues, but more in Cantonese with their clients. With the growing population of immigrants from Mainland China to Hong Kong, the majority of people has little or no knowledge in *Putonghua* (Yau, 1992). When speaking in *Putonghua*, many people in Hong Kong reported difficulties to express themselves, frustration at inappropriate expressions, and resulted in communication breakdown and speechlessness due to psychological pressure and the lack of fluency (Yau, 1992). One of the respondents reported no knowledge in *Putonghua* and mentioned that if the patient was a monolingual Putonghua speaker, and he/she did not understand Cantonese, he would try to speak Putonghua. Another respondent who neither has knowledge in *Putonghua* reported using nonverbal communication skills to facilitate communication with monolingual *Putonghua* speaking patients.

Pierson (1988) examined over a thousand Hong Kong undergraduates of their attitudes toward English, *Putonghua* and Cantonese by means of a content analysis of 100. It has been demonstrated that in almost 50 per cent of this written corpus, whenever *Putonghua* was mentioned, it was related to the context of discussing political and sociocultural issues. *Putonghua* may possibly triggers off a strong sense of ethnic consciousness. Hong Kong Cantonese speaking Chinese, by valuing *Putonghua*, were affirming their Chinese ethnic identity. These Cantonese speaking subjects expressed feelings of shame and incompleteness because they were unable to communicate in *Putonghua*. Putonghua may, therefore, symbolize Chineseness and Chinese cultural values to these students, while English symbolizes Westernization and modernization.

Thus, it is important to raise the local physiotherapists' awareness on their language use. Consciousness raising is "simultaneously an individual and a group experience of empowerment. It can contribute to psychological change for the individual and social transformation for groups and communities" (Henderson, 1995, p. 64). Any changes resulted from consciousness raising occurs in a process of enlightenment, empowerment and emancipation. Enlightenment is "the experience of coming to see oneself in a radically new way by engaging in a dialogue that is a process of self-reflection and theorizing" (p. 64). Empowerment is "the process by which a group of individuals become galvanized to act on their own behalf. It is also a state of feeling more powerful and having an ability to affect others and to change social institutions" and emancipation is "the state of being in which people come to know who they are and have the collective power

to determine the direction of their existence" (p. 64).

Prior to strategies or resolutions can be made to improve the present language situation in health care contexts, understanding of the underlying picture is essential. Sociolinguistics serves mainly for explaining various phenomena concerning linguistics with regard to social system (Chen & Chen, 1990). Some respondents in the present study have called for the standardization of language use in health care settings. At the present language system in Hong Kong, most of the physiotherapists are educated in secondary schools teaching in either Chinese and English, or both. In their tertiary education, English is the main medium of instruction, although mixing of Cantonese and English is used in tutorials and discussion (Gibbons, 1983, 1987). They talk to their colleagues and supervisors mainly in mixing of Cantonese and English, but switching to Cantonese in some occasions, and writing the bednotes and reports to other professionals in English in most of the time. It is the most common language use by the local physiotherapists. But different physiotherapists may have different practice. It may generate inefficient communication and even lead to communication breakdown, and endanger the quality of health care services.

The corpus in this study does not show that language has been utilized by the physiotherapists in Hong Kong as an asset to gain social power. Yet one of the respondents argue that even though proficiency in English does not give a therapist a higher social power in the long run, it impresses patients and other health care professionals for a short period of time. According to the interviewee:

> It is because Hong Kong is an international trading centre, lack of fluency in English may cause problems. For instance, you have contact with foreigners, and you have to meet doctors and other health care professionals. It is an important tool for communication....If you do not use English, and you attend a meeting, where all the doctors speak English. You, as a representative of a department, it would be rather... (Case 3, p. 175)

Studies (Raven, 1988; Ong et al., 1995) have showed that patients complied with their doctors' advice if they could understand the advices. Effective communication between health care professionals and patients is a prerequisite to patients' satisfaction (Lane, 1983; Ong et al., 1995; Street & Wiemann, 1987). Efficient communication, by promoting patients' understanding, is expected to generate greater patient compliance on treatment protocols and recommendations (Anderson, Rakowski & Hickey, 1988; Cousins, 1988: Gums & Carson, 1987; Hamadeh, 1987; Like & Steiner, 1986). Studies have consistently demonstrated patients' understanding was in a positive relation to compliance (Carter et al., 1982; Eraker, Kirscht & Becker, 1984; Greene, et al., 1982; Jette, 1982). "Position-centered" approach and "person-centered" approach" (Kline & Ceropski, 1984, p. 120) are two common approaches in health care consultations. The recent orientation towards person-centered approach is based on that a therapist conceptualize his or her own interactional roles, and is flexible in

accommodation to interpersonal communication. Therapists taking a person-centered approach concerned their patients' needs, attitudes, and feelings and to use such information in diagnosis and treatment. It is relatively rare for bilingual speakers to have equal abilities in both languages. In health care settings, bilingual patients may feel uncomfortable to express that feelings and concerns with a language that they do not feel confident or fluent (Roberts, 1996). Physiotherapists in Hong Kong have to raise their awareness on language use to allow patient to express freely for mutual understanding and to provide bases for usage of concise and precise code of language for communication.

Admittedly, interpersonal communication is one of the fundamental tools in health care contexts. However, several studies have found that health care professionals perceived talking with patients as less important and less effective than sophisticated technology (Armstrong-Ester & Browne, 1986; Kagan, 1985). In a study investigating of the use of verbal and non-verbal communication skills by the physiotherapy students, the results suggested that the students had sufficient knowledge of interpersonal communication, and considered communication skills important during the treatment. It, however, demonstrated they had not been adequately equipped with the skills and overestimated their clinical use of interpersonal communication skills (Dockrell, 1988).

This has already generated predicaments in communication among health care professionals and clients, because of a range of proficiency in the three varieties of languages attained. Hirvela (1991) has labeled this language pattern in

Hong Kong as "linguistic schizophrenia" (p. 124). Further complications have been generated due to prevalence of code-mixing and code-switching. A series of medical blunders caused by misunderstanding of the meaning of words in this bilingual community have already happened (Wan, 1997). It is of great importance to arouse their awareness of language use in Hong Kong. Any misunderstanding or communication breakdown may endanger the quality of health care services provided. Yet prior to any improvement of the current language situation can be made, it is necessary to have a clear picture on this issue, and the paucity has called for research in this area.

The present study is useful and necessary because the study is undertaken not just to further inform our understandings of how the local physiotherapists use language *per se* but also to inform our understandings of the social means by which the local physiotherapists mediate power as they encounter them. The choice and use of language in a bilingual health care setting is a complex issue affected by personal attitudes, identity, power relationships and language status. It is essential that, education programmes focus on language awareness and offer students the chance to discuss and understand the power relationship inherent in choice of language in the health setting. These suggestions provide exciting challenges to the profession since there has been no previous input of this nature at a formal level. Language developments have far-reaching implications for education and may lead to positive outcomes, patient satisfaction and patient compliance (Ong et al., 1995), for health care in the bilingual community. This study has examined the local physiotherapists' language use in their interactions

with patients, to provide the core knowledge of language use that could be usefully applied in other multicultural and multilingual health care settings.

Sociolinguistic study is intended to make predictions and explanations of language behaviour (Chen & Chen, 1990). The impending political and historical changes in Hong Kong, may inevitably bring about social, psychological, cultural and linguistic changes. Studying language behaviours of the physiotherapists in health care settings from a social psychological perspective may in some ways facilitate understanding of the present language situation. Understanding of language behaviour is in essence prior to any explanations and predictions of language phenomena can be made. Owing to the great emphasis of social status and social power ruling language behaviour in Chinese culture, these variables are especially needed to explain the language behaviour in Hong Kong. Another value of this language survey is to offer a reliable corpus of data serving as a reference for the profession as well as other relevant parties for further parties.

It is necessary to include training of the physiotherapy students to acquire communication skills to meet the demands for interpersonal communication with patients during health care encounters. The current medical and paramedical education is focused on sophisticated technologies and skills (Dockrell, 1988). Treating patients with skills and technologies are not enough. It is also important to include affective dimension of their patients. The curriculum for the physiotherapy course need to allow physiotherapy students to explore and develop their knowledge, attitudes and skills linguistically in such a bilingual community

in Hong Kong (Roberts, 1996).

The recent controversy about the medium of instruction in secondary schools has laid out the implications that educators have to review the recent language system in Hong Kong (Lau, 1998). Cantonese is the mother tongue of most of the people in Hong Kong (Pennington, 1994b), but many of the physiotherapists are educated English medium institutes in tertiary education. Under the sociolinguistic conditions in Hong Kong, physiotherapists uses English for verbal communication under quasi-naturalistic conditions at schools, but mainly Cantonese and mixing of Cantonese and English are used in workplace domains (So, 1992). But the future languages needs is that a linguistic environment of Cantonese, *Putonghua* and English. Therefore, educators, physiotherapists, students and researchers have to tackle with the language problems in Hong Kong.

5.3 Limitations and Recommendations

The language habit of mixing English into Cantonese is ubiquitous in Hong Kong (Li, 1996). In the present study, many respondents have reported using this language choice in some domains. To what extent English has been mixed to use with Cantonese has not been explored in this study. Gibbons (1987) used the term "mix" to represent the code-mixing behaviour typical of Hong Kong bilinguals. Even though mixing of languages, mixing of English and Cantonese for instance, represents a clear picture that two languages are used concurrently and reveals language behaviour of bilinguals, it has generated some confusion in

the actual pattern of language behaviour. Li (1996) suggested that

> 'MIX' obscures the fact that the language matrix in Hong Kong is in fact much more complex. For one thing, evidence abounds, especially in writing, that in extreme cases the mixing of varieties in the territory may involve up to four linguistic resources, namely, Cantonese, English (both British English and American English), standard written Chinese, and, to a lesser extent, classical Chinese (as can be found in, but not limited to, many Cantonese pop songs). Hence the use of the term 'MIX' to designate the mixing between English and Cantonese would have been too narrow and rigid for a study that makes use of essentially data from the printed media. (pp. 17-18)

For the present study, it is focused on language behaviour of the local physiotherapists, and to ascertain their language choices in various domains. The scope is to set up a general linguistic repertoire of the physiotherapists in Hong Kong in six domains, usage of language choices selected among Cantonese, English and *Putonghua*, and/or the mixed code. Study of the extent of code-mixing and code-switching from a linguistic point of view is not included in this study. In addition, two varieties of Chinese language are concerned, that are Cantonese and *Putonghua*. Other Chinese dialects such as *Chiu Chau, Hakka, Fukien, Sze Yap* and *Shanghainese* have not been studied.

Tse (1992) designated code-mixing as a more desirable term to describe the common language behaviour in Hong Kong. Some scholars have made theoretical distinction between code-switching and code-mixing (Hamers & Blanc, 1989; Kachru, 1983; Kamwangamalu, 1992, Luke, 1984; Morrow, 1987; Sridhar & Sridhar, 1980). Code switching is referred as switches that coincide with the clause boundaries, while switching within the same clause are labelled code-mixing. But other scholars prefer to use code-switching to cover both the inter-sentential and intra-sentential switches. Clyne (1991) and Gumperz (1982) employed the term, code-switching, to describe the alternate use of two languages, either within a sentence or between sentences. Bhatia (1992) used 'mixing' as an covering term to designate both the intra-sentential and inter-sentential mixing of languages. Romaine (1989) suggested that in order to circumscribe terminological problems it was necessary to see code-switching phenomena as continuum as it was too complex to be compartmentalized.

In this study, the use of linguistic repertoire of bilingual physiotherapists in Hong Kong has been linked to the notion of domain. The principal language behaviour of bilinguals is expressed through code-switching (Breitborde, 1983). In order to examine the language use in social encounters, it is important to involve two issues, who the speakers are, and how the language codes are used. But the social meaning of language use cannot be ascertained without recognizing of the role of societal regularities. Social relationships, therefore, are organized into a system, and the interrelationships at the level of the social system are relevant at some particular moment in some particular interactions. Fishman

(1972) has put forward that

> The situational analysis of language and behaviour represent the boundary area between micro- and macrosociolinguistic... The very fact that humor during a formal lecture is realized through a metaphorical switch to another variety... must be indicative of an underlying sociolinguistic regularity, which obtained before the switch occurred, perhaps of the view that lecture-like or formal situations are generally associated with one language or variety whereas levity or intimacy is tied to another. Without such a view, without a more general notion assigning a particular topic or situation, as one of a class of such topics or situations, to one language rather than to anther, metaphorical purposes could neither be served nor recognized (pp. 449-450).

Domains, the core of the conceptual framework used in this study, are characterized by topics, role-relationships and locales. They are higher order summation of the association of particular role relationships, topics and locales, but are abstract. It is not clear how these three components of domains related to behaviour. As domains are considered as a whole to relate to particular language behaviour, the underpinning relationship between the three factors need further understanding. Would it possible there are different weightings of the three factors? What is the working mechanism of the three components functioning in the notion of domain?

Individuals within a community are linked to each other through a variety of social relationships. Thus, there may be overlapping of domains. The question of the interrelationships of domains at the macrolevel had not been raised in this study, but domains allow us to recognize on the basis that a particular status in a situation is primarily defined, or if a particular status outweigh any others in a particular situation (Breitborde, 1983). Another limitation of this study is that domains are indefinite in number (Fishman, 1972). Only six domains have been investigated in this study, further study may include other ranges of domains.

This study mainly concentrates on the verbal form of communication of the physiotherapists in Hong Kong. It does not mean language behaviour of the use of written form of languages is not worthy studying. Indeed, studying verbal communication is more appropriate for the present situation is because of the fact that Chinese script is based on a morphemic writing system. A monolingual *Putonghua* speaker can still understand what a monolingual Cantonese speakers writes since they write in the same form of Chinese, although there are variations in some of their vocabulary used (Lou, 1992). But, no exaggeration to say, a monolingual *Putonghua* speaker may not understand what a monolingual Cantonese speaks. Disorder in language use may be attributed to the common practice in Hong Kong. When this happens in health care contexts, it may hamper the success of health care consultations, or lower the efficiency of the helping process (Thompson & Pledger, 1993).

There is a wide range of social factors that may relate to language behaviour, the present study mainly focus on the variable of social power (Roberts, 1996). Chen and Chen (1990) advocated that individuality and sociality were the two main components which could help explain language behaviour. Chinese culture lays great attention on human relationship and restricts speech by social rules which are related to interlocutors' social power. More importantly, in health care setting, there is an unequal base of power between therapists and patients, and between different ranks (Roberts, 1996). This study intends to investigate the physiotherapists' of their use under this unequal bases. The generalization of the present study is limited by the method of sampling. The method used in this study is convenient sampling, not random sampling. It is, therefore, confined the representativeness of the linguistic repertoire set up in this study to a small portion of physiotherapists of their language choice with regard to different domains.

Chapter Six

Conclusion

The present language situation for the local professionals working in the profession of physiotherapy is schizophrenic in certain aspects (Hirvela, 1991). Cantonese, English and *Putonghua*, and the mixed code of the three varieties are used in different situations. The medium of instruction for physiotherapy students in Hong Kong is legitimately in English. Similar to other university students, physiotherapy students in Hong Kong use mixed code of Cantonese and English during tutorials and other less formal situations (Pennington, 1994b). But due to the overwhelming number of Cantonese speakers in Hong Kong, about 98 per cent of the Hong Kong population, the local physiotherapists most of the time use Cantonese in clinical settings. The recent soaring number of immigrants from Mainland China, where most of them are native *Putonghua* speakers, and the growing importance of Putonghua as another high variety in Hong Kong, physiotherapists are under the pressure to grapple with the language problems. There is about a quarter of the people in Hong Kong do not have any knowledge in *Putonghua* (Yau, 1992). Risks for communication breakdown or inefficient communication may be resulted from the current language problems in Hong Kong as a monolingual *Putonghua* speaker and a monolingual Cantonese may not understand each other because of the phonetic and lexical difference between Cantonese and *Putonghua* (Bruche-Schulz, 1997).

Interpersonal communication is one of the fundamental tools in health care contexts. It also acts as a prerequisite to patients' satisfaction and patient compliance, by virtue of promoting patients' understanding (Lane, 1983; Ong et al., 1995; Street & Wiemann, 1987). Several studies have found that health care professionals perceived talking with patients as less important and less effective than sophisticated technology (Armstrong-Ester & Browne, 1986; Kagan, 1985). In a study investigating of the use of verbal and non-verbal communication skills by the physiotherapy students, the results suggested that the students had sufficient knowledge of interpersonal communication, and considered communication skills important during the treatment. It, however, has demonstrated they had not been adequately equipped with the skills and overestimated their clinical use of interpersonal communication skills (Dockrell, 1988).

Before modifying the language use in physiotherapy, we should first explore the language behaviour of the physiotherapists in Hong Kong. Using respectful but accurate language when speaking to our clients may have a favorable impact on the outcome of treatment (Spaniol & Cattaneo, 1994). Language can be empowering, the language we use can affect patient understanding and patient compliance. In health care setting, the flow of information need to accurate and achieve mutual understanding between the interlocutors (VanCott, 1993).

Language behaviour of the physiotherapists in Hong Kong is examined in an attempt to set up a linguistic repertoire of the local physiotherapists in six different domains, and to explore the underlying social psychological factors related to their language use. Social power is selected as a variable for in-depth inquiry. Perception on ethnolinguistic vitality is also addressed.

A series of medical blunders caused by misunderstanding of the meaning of words in this bilingual community have already happened (Wan, 1997). It is of great importance to arouse their awareness of language use in Hong Kong. Any misunderstanding or communication breakdown may endanger the quality of health care services provided. Yet prior to any improvement of the current language situation can be made, it is necessary to have a clear picture on this issue, and the paucity has called for research in this area. Fishman's (1972) domain theory of language behaviour (1972) is adopted to organize the corpus of the local physiotherapist language use on the basis of six domains, which comprise interlocutors, locales and topics. The conception of French and Raven's (1959) basis of power are used to measure the participants' perception on social power. Similar to any therapeutic relationship, there is an imbalance of power base exists among physiotherapists and their clients (Spaniol & Cattaneo, 1994). Language may be used as a social instrument to reflect power (Cheung, 1984).

Results show that different varieties of language were chosen with regard to different domains. Cantonese is used more frequently by the participants when they are in the domain at home with their parents (82%) and the domain at home with their siblings (47.5%), as well as in the domain of a health care setting with their patients (61.7%). Mixing of Cantonese and English, however, is used more frequently in the domain of workplace with colleagues (86.9%), domain in workplace with supervisors (85.0%), and domain in social gathering with friends (61.7%). From the data it is also found that there is difference in the language choice with respect to the six domains. No supporting data shows that there is any relationship between the language use and the perception of social power.

Cantonese is used more often by the local physiotherapists to communicate with the patients in health care contexts, difficulties in communications have been reported. There is an soaring number of immigrants from Mainland China. Only a quarter of people in Hong Kong reported using *Putonghua* as a usual language or as another language, and many people claimed an inability to express themselves fully, frustration at inappropriate expressions, and resulted in communication breakdown and speechlessness when speaking *Putonghua* due to the lack of fluency (Yau, 1992). Most of the physiotherapists in Hong Kong are Cantonese-English bilinguals may in some extent having difficulties when communicating with monolingual *Putonghua* speakers. The flow of information in health care settings need to be concise and precise, physiotherapists in Hong Kong have to aware on their language use to facilitate patient understanding and desirable medical outcomes. Language symbolizes

power and has been used by some health care professionals for gaining power. Cantonese, English, *Putonghua* and the mixed code have differentiated language status and functions, however, do not seem to have any relationship with social power in the contexts of communication between the physiotherapists in Hong Kong and their patients. One of the possible explanation is that the physiotherapists in Hong Kong has placed emphasis on patient understanding during verbal communication with their patients in health care setting and, therefore, Cantonese is most often use when talking with patients.

This study supports Fishman's (1972) domain theory of language behaviour that language choice in a bilingual speech community is based on topic, interlocutors and locale. The physiotherapists in Hong Kong use different language varieties in different domains. Further research may explore the distinctive functions of topic, interlocutors and locale in language use, and the inter-relationship among these factors. Moreover, the relationship between social power and language use in the context of health care setting needs further investigation.

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Appendix I

Interview Guide

Prologue

First of all, thank you for your taking part in our research study upon our invitation. Before we start our interview, I would like to give you some more details about it. This interview will last for about an hour, and it aims at gaining an insight into the point of view of health care professionals in Hong Kong of their opinions on language use and some other issues. This interview will be tape-recorded and transcribed. During the interview, if there are any questions asked make you feel uncomfortable, you may refuse to answer them, or even terminate the interview at any time. All your information will be kept confidential and anonymous, and the tapes will be eradicated once the study is finished. Do you have any questions?

Content of Interview

1a) In a scale of ten, how many marks will you give on the level of your language proficiency in Chinese?

1b) In a scale of ten, how many marks will you give on the level of your language proficiency in English?

2a) How well do you write in Chinese?

2b) How well do you write in English?

2c) How fluent do you speak Cantonese?

2d) How fluent do you speak English?

2e) How fluent do you speak *Putonghua*?

3a) Under what situation will you speak Cantonese? What are the underlying factors that make you choose among Cantonese, English, and Putonghua to use?

3b) Under what situation will you speak English? What are the underlying factors that make you choose among Cantonese, English, and *Putonghua* to use?

3c) Under what situation will you speak *Putonghua*? What are the underlying factors that make you choose among Cantonese, English, and *Putonghua* to use?

4a) What language/dialect do you usually choose when you are talking to your parents? Why?

4b) What language/dialect do you usually choose when you are talking to your siblings? Why?

4c) What language/dialect do you usually choose when you are talking to your friends? Why?

4d) What language/dialect do you usually choose when you are talking to your colleagues? Why?

4e) What language/dialect do you usually choose when you are talking to your supervisors? Why?

4f) What language/dialect do you usually choose when you are talking to your patients? Why?

5) Why do you sometimes use a mixing of languages?

6) Are there any relationship between language choices and interlocutors? Please explain briefly.

7) Are there any relationship between language choices and locules? Please explain briefly.

8) Are there any relationship between language choices and topics? Please explain briefly.

9) What about the inter-relationship between interlocutors, locules, topics, and language choices?

10) What is your opinion on the current language system in Hong Kong?

11) Do you think interpersonal communication between physiotherapists and patients important in health care setting? Why?

12) Are there any difficulties when you are communicating with your patients?

13) Do you think any improvement needed to be made on communication between physiotherapists and patients?

14) Do you sometimes find it difficult to give advices or explanation to your patients in Cantonese or *Putonghua* but what your have learnt from school is in English?

15) What is your opinion on the social power of the physiotherapists in Hong Kong, as health care professionals?

16) Do you think speaking in one particular kind of language/dialect to your patients would gain higher social power than in another kind of language?

17) If yes, which one do you think, Cantonese, English or *Putonghua*, will give you higher social power? Why?

Appendix II

Questionnaire of Language Behaviour of the Physiotherapists in Hong Kong

THE HONG KONG
POLYTECHNIC UNIVERSITY
DEPARTMENT OF NURSING & HEALTH SCIENCES
BEHAVIOURAL SCIENCE SECTION

Questionnaire of Language Behaviour

Efficient communication is important in physiotherapy consultation. Sophisticated technologies are used for physical examination and treatment, whereas interpersonal communication is the fundamental instrument for information exchange between physiotherapists and their clients. Through communication, physiotherapists can understand better about the social and psychological aspects of their clients. Owing to the fact that physiotherapists in Hong Kong are now working under a dynamic cultural, social, economic, and linguistic situation, they have to get prepared to meet the demands of the present versatile situation.

The purpose of this study is to ascertain the language use of the physiotherapists in Hong Kong from a social and psychological perspective. I, therefore, would like to seek your valuable opinions on language use. Your participation is really important and the information collected may contribute to improvement in communication among physiotherapists or with clients. All the information will be kept **CONFIDENTIAL** and your right of anonymity is assured.

Reference No.: MSPT1-_____

In this questionnaire, we are interested in what you think of different language usage. You may feel that you have insufficient information at your immediate disposal to answer these questions, yet it is your *impressions* that we are interested in. Please feel free to express your point of view. Please read the instructions carefully and answer ***each*** item on the questionnaire.

Section 1

Please ***tick*** the appropriate one.

1. **Which language/dialect do you most often use when you talk to your parent(s) at home?**

   ☐ 1) Cantonese only
   ☐ 2) English only
   ☐ 3) Putonghua only
   ☐ 4) Mixing of Cantonese and English
   ☐ 5) Mixing of Cantonese and Putonghua
   ☐ 6) Mixing of Putonghua and English
   ☐ 7) Mixing of Cantonese, English and Putonghua
   ☐ 8) Others: (please specify) _____
   ☐ 9) Not applicable

2. **Which language/dialect do you most often use when you talk to your sibling(s) at home?**

   ☐ 1) Cantonese only
   ☐ 2) English only
   ☐ 3) Putonghua only
   ☐ 4) Mixing of Cantonese and English
   ☐ 5) Mixing of Cantonese and Putonghua
   ☐ 6) Mixing of Putonghua and English
   ☐ 7) Mixing of Cantonese, English and Putonghua
   ☐ 8) Others: (please specify) _____
   ☐ 9) Not applicable

3. **Which language do you most often use when you talk to your colleague(s) in a workplace?**

   ☐ 1) Cantonese only
   ☐ 2) English only
   ☐ 3) Putonghua only
   ☐ 4) Mixing of Cantonese and English
   ☐ 5) Mixing of Cantonese and Putonghua
   ☐ 6) Mixing of Putonghua and English
   ☐ 7) Mixing of Cantonese, English and Putonghua
   ☐ 8) Others: (please specify) _____
   ☐ 9) Not applicable

4. **Which language/dialect do you most often use when you talk to your supervisor(s)/boss in a workplace?**

   ☐ 1) Cantonese only
   ☐ 2) English only
   ☐ 3) Putonghua only
   ☐ 4) Mixing of Cantonese and English
   ☐ 5) Mixing of Cantonese and Putonghua
   ☐ 6) Mixing of Putonghua and English
   ☐ 7) Mixing of Cantonese, English and Putonghua
   ☐ 8) Others: (please specify) _____
   ☐ 9) Not applicable

5. **Which language/dialect do you most often use when you talk to your friend(s) in a social gathering?**

   ☐ 1) Cantonese only
   ☐ 2) English only
   ☐ 3) Putonghua only
   ☐ 4) Mixing of Cantonese and English
   ☐ 5) Mixing of Cantonese and Putonghua
   ☐ 6) Mixing of Putonghua and English
   ☐ 7) Mixing of Cantonese, English and Putonghua
   ☐ 8) Others: (please specify) _____
   ☐ 9) Not applicable

6. Which language/dialect do you most often use when you talk to your patient(s) in a health care setting?

- ☐ 1) Cantonese only
- ☐ 2) English only
- ☐ 3) Putonghua only
- ☐ 4) Mixing of Cantonese and English
- ☐ 5) Mixing of Cantonese and Putonghua
- ☐ 6) Mixing of Putonghua and English
- ☐ 7) Mixing of Cantonese, English and Putonghua
- ☐ 8) Others: (please specify)_____
- ☐ 9) Not applicable

Section 2

Please *circle* the appropriate one.

7. How highly regarded are the following languages/dialect in Hong Kong?

	Not at all				Extremely highly
7.1 ***CANTONESE***	1	2	3	4	5
7.2 ***ENGLISH***	1	2	3	4	5
7.3 ***PUTONGHUA***	1	2	3	4	5
7.4 Mixing of ***CANTONESE & ENGLISH***	1	2	3	4	5
7.5 Mixing of ***CANTONESE & PUTONGHUA***	1	2	3	4	5
7.6 Mixing of ***PUTONGHUA & ENGLISH***	1	2	3	4	5
7.7 Mixing of ***CANTONESE, ENGLISH & PUTONGHUA***	1	2	3	4	5

8. How highly regarded are the following languages/dialect internationally?

	Not at all				Extremely highly
8.1 ***CANTONESE***	1	2	3	4	5
8.2 ***ENGLISH***	1	2	3	4	5
8.3 ***PUTONGHUA***	1	2	3	4	5

9. How often are the following languages/dialect used in Hong Kong government services (e.g., health clinics, social welfare, etc.)?

	Not at all				Exclusively
9.1 CANTONESE	1	2	3	4	5
9.2 ***ENGLISH***	1	2	3	4	5
9.3 ***PUTONGHUA***	1	2	3	4	5
9.4 Mixing of ***CANTONESE & ENGLISH***	1	2	3	4	5
9.5 Mixing of ***CANTONESE & PUTONGHUA***	1	2	3	4	5
9.6 Mixing of ***PUTONGHUA & ENGLISH***	1	2	3	4	5
9.7 Mixing of ***CANTONESE, ENGLISH & PUTONGHUA***	1	2	3	4	5

10. How much control do the following groups have over economic and business matters in Hong Kong?

	None at all				Exclusive
10.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
10.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
10.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5
10.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
10.5 People of Chinese descent who speak mixing of ***CANTONESE*** **and** ***PUTONGHUA***	1	2	3	4	5

10.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
10.7 People of Chinese descent who speak mixing of ***CANTONESE***, ***ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

11. How well-represented are the following languages/dialect in the Hong Kong mass media (e.g. TV, radio, and newspapers)?

	Not at all				Extremely well
11.1 ***CANTONESE***	1	2	3	4	5
11.2 ***ENGLISH***	1	2	3	4	5
11.3 ***PUTONGHUA***	1	2	3	4	5
11.4 Mixing of ***CANTONESE & ENGLISH***	1	2	3	4	5
11.5 Mixing of ***CANTONESE & PUTONGHUA***	1	2	3	4	5
11.6 Mixing of ***PUTONGHUA & ENGLISH***	1	2	3	4	5
11.7 Mixing of ***CANTONESE, ENGLISH & PUTONGHUA***	1	2	3	4	5

12. How highly regarded are the following groups in Hong Kong?

	Not at all				Extremely highly
12.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
12.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
12.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5

12.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
12.5 People of Chinese descent who speak mixing of ***CANTONESE*** **and** ***PUTONGHUA***	1	2	3	4	5
12.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
12.7 People of Chinese descent who speak mixing of ***CANTONESE***, ***ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

13. How much are the following languages taught in schools in Hong Kong?

	Not at all				Exclusively
13.1 ***CHINESE***	1	2	3	4	5
13.2 ***ENGLISH***	1	2	3	4	5

14. How much are the following languages taught in universities in Hong Kong?

	Not at all				Exclusively
14.1 ***CHINESE***	1	2	3	4	5
14.2 ***ENGLISH***	1	2	3	4	5

15. How much political power do the following groups have in Hong Kong?

	None at all				Complete
15.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
15.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
15.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5

15.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
15.5 People of Chinese descent who speak mixing of ***CANTONESE*** **and** ***PUTONGHUA***	1	2	3	4	5
15.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
15.7 People of Chinese descent who speak mixing of ***CANTONESE, ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

16. How well-represented are the following spoken languages/dialect in business institutions in Hong Kong?

	Not at all				Exclusively
16.1 ***CANTONESE***	1	2	3	4	5
16.2 ***ENGLISH***	1	2	3	4	5
16.3 ***PUTONGHUA***	1	2	3	4	5
16.4 Mixing of ***CANTONESE & ENGLISH***	1	2	3	4	5
16.5 Mixing of ***CANTONESE & PUTONGHUA***	1	2	3	4	5
16.6 Mixing of ***PUTONGHUA & ENGLISH***	1	2	3	4	5
16.7 Mixing of ***CANTONESE, ENGLISH & PUTONGHUA***	1	2	3	4	5

17. How well-represented are the following written languages in business institutions in Hong Kong?

	Not at all				Exclusively
17.1 ***CHINESE***	1	2	3	4	5
17.2 ***ENGLISH***	1	2	3	4	5

18. How proud of their cultural history and achievements are the following groups in Hong Kong?

	Not at all				Extremely highly
18.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
18.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
18.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5
18.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
18.5 People of Chinese descent who speak mixing of ***CANTONESE*** **and** ***PUTONGHUA***	1	2	3	4	5
18.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
18.7 People of Chinese descent who speak mixing of ***CANTONESE***, ***ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

19. How well-represented are the following groups in the cultural life of Hong Kong (e.g., festivals, concerts, art exhibitions)?

	Not at all				Extremely highly
19.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
19.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
19.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5
19.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
19.5 People of Chinese descent who speak mixing of ***CANTONESE*** **and** ***PUTONGHUA***	1	2	3	4	5
19.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
19.7 People of Chinese descent who speak mixing of ***CANTONESE***, ***ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

20. How strong and active do you feel the following groups are in Hong Kong?

	Not at all				Extremely highly
20.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
20.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
20.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5

20.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
20.5 People of Chinese descent who speak mixing of ***CANTONESE* and *PUTONGHUA***	1	2	3	4	5
20.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
20.7 People of Chinese descent who speak mixing of ***CANTONESE***, ***ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

21. How wealthy do you feel the following groups are in Hong Kong?

	Not at all				Extremely highly
21.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
21.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
21.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5
21.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
21.5 People of Chinese descent who speak mixing of ***CANTONESE* and *PUTONGHUA***	1	2	3	4	5
21.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
21.7 People of Chinese descent who speak mixing of ***CANTONESE***, ***ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

22. How strong and active do you feel the following groups will be 20 to 30 years from now?

	Not at all				Extremely highly
22.1 People of Chinese descent who speak ***CANTONESE*** only	1	2	3	4	5
22.2 People of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
22.3 People of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5
22.4 People of Chinese descent who speak mixing of ***CANTONESE*** and ***ENGLISH***	1	2	3	4	5
22.5 People of Chinese descent who speak mixing of ***CANTONESE*** **and** ***PUTONGHUA***	1	2	3	4	5
22.6 People of Chinese descent who speak mixing of ***PUTONGHUA*** and ***ENGLISH***	1	2	3	4	5
22.7 People of Chinese descent who speak mixing of ***CANTONESE, ENGLISH*** and ***PUTONGHUA***	1	2	3	4	5

23. In general, how much contact is there between the following groups in Hong Kong?

	None at all				Very much
23.1 People of Chinese descent who speak ***CANTONESE*** only and people of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5
23.2 People of Chinese descent who speak ***CANTONESE*** only and people of Chinese descent who speak ***PUTONGHUA*** only	1	2	3	4	5

23.3 People of Chinese descent who speak ***PUTONGHUA*** only and people of Chinese descent who speak ***ENGLISH*** only	1	2	3	4	5

Section 3

Please indicate how much you agree or disagree with each of the following statements and ***circle*** the appropriate one.

	Agree				**Disagree**
24. According to a socially accepted idea, it is natural for my patients to do what I want.	1	2	3	4	5
25. My patients have to conform to me/my instructions.	1	2	3	4	5
26. My patients have to listen to me/my instructions.	1	2	3	4	5
27. I do not have the right to tell my patients how to act.	1	2	3	4	5
28. I can decide all treatments for my patients so that everything is all right.	1	2	3	4	5
29. My patients are impressed by my professional knowledge and skills.	1	2	3	4	5
30. I have more knowledge than my patients have.	1	2	3	4	5
31. I have many clinical experiences and professional knowledge like an expert in the physiotherapy field.	1	2	3	4	5
32. When I oppose my patients, I usually change my patients' opinion.	1	2	3	4	5
33. I cannot request anything of my patients.	1	2	3	4	5
34. I influence my patients in a variety of situations.	1	2	3	4	5
35. I can make a request of my patients for a slightly difficult matter.	1	2	3	4	5

36. I would like to have a nice relationship with my patients.	1	2	3	4	5
37. I would like to keep my relationship with my patients.	1	2	3	4	5
38. I am glad to have the present relationship with my patients.	1	2	3	4	5
39. I am satisfied with my relationship with my patients.	1	2	3	4	5

Section 4

Please ***tick*** the appropriate one.

40. What is your age since last birthday?

- ☐ 1) Below 21
- ☐ 2) 21-25
- ☐ 3) 26-30
- ☐ 4) 31-35
- ☐ 5) 36-40
- ☐ 6) 41-45
- ☐ 7) over 45

41. What is your gender?

- ☐ 1) Male
- ☐ 2) Female

42. What is your mother tongue?

- ☐ 1) Cantonese
- ☐ 2) English
- ☐ 3) Putonghua
- ☐ 4) Others: (please specify) _____

43. What is your highest education level achieved?

- ☐ 1) Post-secondary
- ☐ 2) Professional Diploma
- ☐ 3) Bachelor Degree
- ☐ 4) Postgraduate Diploma
- ☐ 5) Master Degree
- ☐ 6) Doctor of Philosophy
- ☐ 7) Others: (please specify) _____

44. Which is/are the medium of instructions of your secondary school(s)? (you may tick more than one)

- ☐ 1) Chinese only
- ☐ 2) English only
- ☐ 3) Chinese and English
- ☐ 4) Others: (please specify) _____
- ☐ 5) Not applicable

45. How many years of working experience in the field of physiotherapy do you have?

- ☐ 1) Less than 5 years
- ☐ 2) 5-10 years
- ☐ 3) 11-15 years
- ☐ 4) 16-20years
- ☐ 5) over 20 years

46. What is the position you are now working?

- ☐ 1) Student
- ☐ 2) Physiotherapist II
- ☐ 3) Physiotherapist I
- ☐ 4) Advanced Practitioner in Physiotherapy
- ☐ 5) Senior Physiotherapist
- ☐ 6) Department Manager
- ☐ 7) General Manager
- ☐ 8) Others: (please specify) _____

THANK YOU FOR YOUR FILLING OUT OF THE QUESTIONNAIRE

Appendix III

Informed Consent

THE HONG KONG
POLYTECHNIC UNIVERSITY
DEPARTMENT OF NURSING & HEALTH SCIENCES
BEHAVIOURAL SCIENCE SECTION

Inform Consent

I am currently a research student and I am undertaking a research project titled "The language behaviours of the physiotherapists in Hong Kong: Studies from a social psychological perspective". The purpose of this study is intended to explore language use of physiotherapists in Hong Kong, and to gain a deeper understanding of their language behaviour.

This study mainly consists of two parts. The first part is in the form of questionnaire to gather physiotherapists' language use in health care setting and their opinion on some issues. After that, interviews will be conducted in the second part to help in-depth understanding of language behaviours of the physiotherapists in Hong Kong.

All the subjects in this study will be identified with numbers instead of their names. They will be kept anonymous. They may refuse to participate or withdraw from the study any time, without being subject to any loss or benefit. All the data gathered will be kept confidential and kept in a locked drawer with the only access by my supervisors and me.

Cordially, I would like to invite you to participate in this study. Should you have any enquiry, please feel free to contact me at 2766 6759.

Yours truly,

Cheung Pui Yee, Polly

Reference no.: MSPT1-

CONSENT FORM

Miss Polly Cheung, who is a student at the Hong Kong Polytechnic University, has requested my participation in the above captioned research study. I have been informed the purpose of the study.

I understand that the results of this research may be published but that my name or identity will not be revealed at any time. In order to keep my records confidential, Miss Polly Cheung will store all information as number codes in a locked drawer and computer files that will only be available to her or her supervisors.

I have been informed that any questions I have at any time concerning the research study or my participation in it, will be answered by Miss Cheung.

I have been informed that I can refuse to participate or withdraw from the study at any time without any loss or benefit.

I have read the above information and I agree to participate in this research.

Signature of participant _____

Name of participant _____

Date _____

Appendix IV

Transcript 1

Q: 係我地開始之前，首先我要多謝你參加我地呢個訪問。或者有少少我想補充就係話呢個 interview 大概會係一個鐘頭左右啦！咁我地其實希望可以加深一下你作爲一個物理治療師，對香港現存個語言運用，同埋一 D 睇法，對呢個行業，同埋一 D 溝通之間既睇法。咁呢個訪問將會係錄音架啦，咁同埋將來都會用黎做研究既資料。咁但係當我地做完呢個研究之後，我地就會將呢盒燒毀，所以你係唔需要擔心。如果係呢個訪問入面，有 D 咩野係令到你覺得唔舒服，或者聽左令你覺得尷尬既話，你可以拒絕回答，甚至乎係終止呢個訪問既。咁所有既資料係絕對保密，同埋係將你既名係不記名既。你有冇咩野問題呢？

A: 冇。

Q: 冇呀，咁我地依家可以開始勒！譬如俾一分至十分裏面，咁一分爲之最低，十分爲之最最高，咁你覺得係你自己語言能力方面，你會俾幾多分呢？首先我地講下中文個方面。

A: 中文……我諗七、八分倒啦！

Q: 唔。咁如果係英文呢？

A: 我諗得三、四分架咋！

Q: 咁如果我地深入 D 了解一下啦，咁譬如係書寫中文方面，你係呢十分入面，你會俾自己幾多分呢？

A: 即係唔係唔可以高過七、八分？

Q: 唔係。

A 即如果我係個十分入面？

Q: 係。

A: 書寫我諗係七、八分啦！

Q: 七至八分。咁如果即係書寫中文方面係七至八分。

A: 係。

Q: 咁如果書寫英文方面呢？

A: 書寫英文方面我諗係三、四分啦！

Q: 三、四分。拿，依家係香港比較普遍用就係廣東話啦、英文同國語，咁如果講廣東話既時候，你覺得自己講個能力有幾多分？

A: 如果講，你諗係八、九分，廣東話既話。

Q: 係。咁英文呢？

A: 你諗係五、六分啦。

Q: 如果係普通話呢？

A: 係零分，因爲我唔識講。

Q: 即普通話你覺得係暫時未識講？

A: 我係唔識講普通話囉。可能聽少少，講得慢都依稀聽到 D，但係就完全唔識講。

Q: 係。咁譬如係日常生活之中，你通常係用咩野語言比較多 D 架？

A: 其實講廣東話多，不過有時可能講講下有時會有一、兩隻字係英文呀咁樣囉。

Q: 咁即主要係廣東話？

A: 係。

Q: 但間中都加插左……

A: 有少少英文。

Q: 咁通常咩情形之下，你可唔可以實質 D 黎講，你會用廣東話呢？

A: 你講緊工作上定日常生活呢？

Q: 即譬如係你一諗起廣東話既時候，通常會係 D 咩情之下呢？

A: 同朋友呀、同病人，或者屋企人其實都會係用廣東話，大部份生活圈子都係用普通話。

Q: 普通話……？

A: 唔係。唔好意思，係廣東話。

Q: 係。咁其實點解係呢 D 情形之下會選用廣東話呢？

A: 因爲一出世就用廣東話，同埋周圍 D 人都會係用廣東話呀麻，咁所以變左好快，同埋好自然會用。同埋你要係即係最容易表達得到，可能一出世就係接觸呢種語言。

Q: 咁係咩情形之下你會用英文呢？

A: 同外國人啦、另外譬如話係醫院醫生巡房呀、或者同一 D 高級 D 醫生講，佢地要用英文既，咁會講囉。咁同埋有時同事之間可能我地講緊病人個 case，咁唔想俾個病人知多我地係度諗緊咩，咁可能會用英文囉。

Q: 即點解呢？點解會係譬如你頭先所講同高級 D 呀……同外國人講好自然啦，因爲譬如佢剩係識呢種語言。佢先至會明白。咁但係譬如點解同高級職員就會用英文？

A: 其實呢個問題係佢地既問題，因爲係 D 高級醫生呀，或者高級既要員，佢地用英文同你講野。咁你好自然用番英文同佢講野。係佢地用英文，咁我地唯有都用英文。

Q: 咁同埋你頭先所講就係話係好想俾病人聽倒個情形。咁可唔可以請你詳細講下？

A: 譬如話有陣時你要知道我地物理治療依家係香港既制度係有好多時 D 野 D 醫生唔係好鍾意由其他既 professional 去講架。或者習慣上有咩要交代就由醫生去交代，同埋佢地比較全面 D 囉應該。咁當我地譬如話講緊個 case 既時候，發覺我地 query 一 D problems，可能屋企人係唔知架，就算我地係 query 緊，大家都係估緊既時候，咁好似唔係好應該俾個病人既家屬知住，因爲都未 confirm，咁所以我地會用英文講。可能我地有時又會衰啦，係度討論一下醫生既 management 係有 D 問題，或者係一般會係點呀，咁所以可能會用英文講囉，就係咁勒。

Q: 頭先你都提過，你話自己唔係好識普通話，咁有冇一 D 情形之下你都會嘗試去用普通話同人溝通呢？

A: 會既。咁但係如果個病人真係唔識講廣東話既，唔識聽既，咁咪會嘗試講 D 囉。或者真係個環境裏面，係個街度，有個普通話既人黎問路，可能你夾硬將 D 所謂既普通話都會講幾句既。

Q: 請你講係咁既情形之下你自己既感受係點樣架？

A: 好好笑囉，就唔會覺得唔識普通話未至於一個好大既問題。好多時覺得普通話會係 D 廣東話咩 D 音都好似有 D 似樣，所以就係咁樣囉。

Q: 頭先你提過呢你間中就會即係講野既時候夾雜一、兩個英文字。咁其實有 D 咩情形之下，可唔可以譬如講下最普遍用到夾雜中、英咁樣？

A: 咁其實頭先講個大乍野都會有囉。咁其實有時講開醫院既野，因爲平時用開 D 詞語都會係英文既時候，咁可能會講一、兩個。咁又好多時同朋友傾偈個陣時都會譬如話返教會會話返 church 呀。或者譬如話去做運動咁咪會講去做 gym 呀咁樣個 D 囉。咁所以其實就會係因爲個趨勢，咁人地講開咁會係講，咁但係冇咩點解、刻意架。

Q: 即係譬如你話大趨勢，咁可唔可以試下再詳細 D？

A: 因爲係香港黎講係好多人依家係中、英文都識講，甚至乎有 D 人可能用英文比用中文更加熟呀，咁所以變左係佢地用中文會有英文字，咁其他人講開就慣左，咁好多時就會有呢個趨勢會去講。咁有陣時其實唔係話唔識講，而係可能習慣上呀、貪懶呀、可能講英文會覺得好似個字容易表達 D、到肉 D，咁咪會用英文囉。

Q: 咁根據份問卷啦，你就話同爹 D、媽咪係屋企既時候呢就通常就會比較上多用廣東話啦，咁可唔可以或者試下請你講下，即係同父母係屋既時候就會用廣東話比較多 D 呢？

A: 因爲佢地唔係好識英文，可能你會講一、兩隻字既英文都會，但係成句英文就唔會囉，因爲佢地唔係好識。

Q: 譬如同細佬、妹啦都係比較多，係屋企既時候多數用廣東話啦，咁有冇一 D 原因？

A: 因爲都係容易表達囉，雖然大家都會識英文，但係最快脆、最方便都係廣東話囉。

Q: 同同事啦，同同事都係用廣東話既……

A: 比較多，因爲大部份都係中國人，咁你好多時講野你都會廣東話囉容易 D、最舒服、最快脆、最方便既語言。咁耐不耐都會英文既，但係都係夾雜一、兩句，但係都係廣東話爲主。

Q: 咁譬如你覺得係一句廣東話入面夾雜一、兩個英文字，你覺得屬唔屬於係都叫做一種中、英夾雜，定抑或你都認爲咁係屬於……

A: 其實我會覺得係如果嚴格黎講我覺得中、英夾雜。但係依家根本個個人都係咁，咁所以其實我覺得都係中文既都好似。甚至乎有時我同阿婆講話「O 唔 O.K.呀？」，咁「O.K.」兩個英文咁阿婆都知我講咩囉。

Q: 咁好啦。咁跟住落黎就同上司啦，上司如果係工作個地方你通常會用中、英兩者之間混合，其實有冇咩特別原因呢？

A: 第一，我有個外國人上司啦。咁其二係佢地囉，因爲好多時譬如同 D 高級醫生講，係佢地用英文呀，咁變左我地都要用番英文同佢地講野囉。咁有時我地老細講講下佢都會係某 D 場合，唔係剩係我同佢架，咁可能重有其他既 professional 係度，咁既環境底下，佢地要講英文，咁既時候我都要講英文囉。

Q: 其實你覺得你上司同你講廣東話多 D 丫，定中、英夾雜，即佢通常用邊一種？

A: 其實講廣東話會比較多 D，即有時如果係 leisure time 傾偈就絕對係一定係廣東話，或者有陣時我同佢兩個有少少野傾既時候一定係廣東話。但係有陣時多 D 人既時候，或者係一 D 環境問題，即係同其他 professional 就會係中、英囉。

Q: 即係其實你覺得係個地點同埋個場合個方面影響到？

A: 係呀。

Q: 同朋友你係揀左廣東話同英文夾啦，咁其實有冇咩特別原因？

A: 其實我都有一、兩個外國朋友啦。其二就係有陣時即係有 D 野佢地又係唔係好識得用中文去表達，就算中國人，對於佢地黎講，佢地會容易用英文去表達。唔係話我講廣東話唔識。聽，可能當我講多幾句，佢唔知我想講咩既時候，我就要英文同佢講野囉。咁始終都會讀左咁多年，好多時都係英文爲主，有陣時講講下，死勒，你會諗唔到個中文點樣講會比到肉 D，你就可能會用英文講囉。

Q: 咁其實係你覺得中、英文夾雜既意思係話譬如一句中同埋一句英咁樣兩者之間夾丫，定抑或係一句中加 D 英文字，或者一句英加 D 中文字？

A: 其實唔係 half and half 既，譬如十句入面譬如話有七句中文、三句英文倒咁囉。

Q: 係。咁同病人呢，譬如通常你做治療既時候你就揀廣東話啦，其實個原因係邊度？

A: 最重要因爲大部份既人都係講廣東話，講中文，即全部都係中國人，咁所以都係講廣東話囉。

Q: 倘若譬如你知道即係個病人教育程度好高呀，係識英文，好流利既，即你會唔會嘗試用其他既言語？

A: 都唔會。因爲對於我自己黎講會舒服 D 囉。我既表達能力中文可能會好 D 我覺得。同埋有陣時你又驚講錯 grammar 丫麻英文。咁所以中文唔怕囉，咁咪容易 D，冇咁多壓力囉我會覺得。

Q: 咁其實你頭先都有提過同唔同既人，即我地都睇倒，會揀唔同既語言。可唔可以請你再詳細……你覺得係語言既選擇同埋個對象，即個對象，即說話既對象，兩者之間有咩關係呢？

A: 除左國籍方面呢，其實理論上我就覺得唔係太大分別既。不過係醫院方面我就覺得 D 高級醫生、D 教授佢地就好鍾意用英文既。所以變左係佢地面前既時候，佢係會講英文囉。咁或者個場合，譬如巡緊房既時候，佢地因爲傳統上都係用英文，我唔知佢地因爲唔想俾 D 病人知道佢地講咩定係點。所以佢地巡房用英文情況底下我地都用英文講。

Q: 其實點解你會即係譬如佢講英文既時候你都.....

A: 都要用英文對答？因爲我諗禮貌上啦，即人地用英文問你，咁我覺得禮貌上都應用英文去答佢。雖然人地識聽，咁人地用英文問你可能有佢既原因，咁我覺得禮貌上尊重番對方應該用英文囉。

Q: 咁如果係語言既選擇同埋係地點或者場合方面，你覺得兩者之間又有 D 咩野既關係？

A: 地點，其實我頭先都答左啦，因爲巡房個 D 傳統上都係做 D 咁既野囉。

Q: 咁最後一個就係話即係我想了解兩者之間既關係就係語言既選擇同埋個題材，或者個話題，你覺得兩者之間有咩關係？

A: 如果你係醫院方面？

Q: 或者任何情況。

A: 我又覺得冇太大關係禍，因爲我覺得冇咩太關係。其實係人物、對象或者個場合會比較緊要 D 囉。如果譬如話同一個話題係唔同既場合，你需要用廣東話，或者呢個英文黎講，但係理論上我就覺得冇咩大關係。

Q: 係。譬如依家講呢幾方面既關係，譬如語言既選擇呀、人物呀、地點同埋題材，你覺得呢幾方面有 D 咩野既關係呢？

A: 即如果將呢幾方面既野 link 埋一齊？

Q: 係。

A: 其實我諗呢係個場合，即係除左個人真係國籍問題之外，你要真係講某一種語言啦，其實我諗係我既生活環境我會覺得個場合係會影響最大囉。影響即係話點解要講廣東話，點解要講英文呀，咁個場合會影響最大，咁但係你話至於個話題我就覺得係冇影響架。可能有時候某程度上係個人物囉，咁個人物既地位問題，即對方佢用咩語言，所以我尊重佢，係佢個選擇權多過我囉我會覺得。

Q: 譬如依家我地拉番開少少啦，譬如講開香港現時個語言個制度，你覺得有 D 咩野意見呀？

A: 其實有一個好大既問題我諗大家都會覺得，即依家既學生出黎甚至乎我自己讀完書出黎，我都覺得好似兩頭唔到岸，中文又唔係好得，英文又唔係好得。可能講你會覺得好 D，但係譬如你叫我書寫起上黎，我真係執筆忘字，完全死勒，中文成日要拿住本字典找既，英文又係會 D 咁既問題，咁但係你話係歸根究底於因爲唔實行母語教學既問題，咁我又覺得唔係。其實我會覺得有少

少係因爲考試制度剩係太過重於呢個考試，根本就冇培養到學生根本係語言方面既興趣同埋去運用囉。咁就算中、英文會考，或者平時考試係會有，但係個問題係真係你會見到呢 D 先生擺左好多時間係 D 課文上面，或者下面根本冇好刻意去真係應付得到，改變個學生個語言能力囉，同埋培養佢語言興趣囉。大家都爲左應付考試，咁你中、英文其實你真係要可能睇多 D，你得閒要寫多 D 咁先至會有進步囉，所以就搞到咁勒！

Q: 係。咁你頭先就講左就係關於個教育制度方面啦。咁譬如你覺得依家係我地呢個物理治療呢個 field 入面係，咁或者都可以係護理界咁，你覺得語言個制度，即係譬如語言個運用，你覺得有咩意見呢？

A: 其實係有個好大既問題架我覺得，但係呢個問題未必可以解決得到。無論醫生、護士、任何一個 professional 係醫院入面，讀既時候都一定係英文，但係我地出黎做既對象又成七、八成，甚至乎係九成係講中文既，你要講廣東話既，咁我覺得係好唔同既，即我會覺得好怪囉。雖然你有時諗 D 野係書本上既一 D 野，你要解釋番俾個人既時候你就要諗勒，你要將個段既英文慢慢去轉番做中文。或者可能有時你自己諗倒既野，可能當你要寫番，你要將佢搬番落去 D record 入面既時候，你點樣慢慢將佢轉番英文，我又覺得係好大 conflict，最大係由我地書本既野要搬番出黎，同我地病人去用既時候你全部要用中文囉，就會覺得好怪好怪囉。可能病人係我地講完之後，佢唔係好知我地想講咩，雖然講中文，佢未係完全明白得晒，因爲都唔知我地講咩，就係咁勒。

Q: 咁會唔會有 D 咩既特別情形，譬如要你寫個報告會特別困難，譬如要寫英文報告？咁因爲現存通常係寫英文報告，同埋真係要同病人用廣東話黎解釋係最困難。有冇一個特別既，令你覺得係因爲語言所以令你係覺得係要工作上作爲物理治療師係有 D 困難既地方？

A: 其實每日既 daily record 其實問題都不大既，因爲都係好公式化，咁但係你話可能解釋俾個病人聽會難 D 架。但係呢個我諗係經驗囉，如果你做耐左，經驗你講得多就會容易 D，即你係識得點去用 D layman term 去解釋番俾佢地聽，佢地會明白。有時候將書本上翻釋做中文既時候呢係一 D 比較唔係咁 layman D 既 term。譬如好公式化既，譬如我地「骨節與骨節之間係點，依家退化勒！」可能我地接觸都比較年紀大，老一輩既，可能同後生 D 既講，佢會明白。但係佢地可能完全唔明白，可能你就要用 D layman 既 term，依家你個關節就生銹勒！咁佢地話：「我明白勒！」即咁樣講囉。咁變左係我諗唔同囉。

Q: 咁譬如你作爲一個專業人士，一個物理治療師，你覺得最好既語言既選擇，譬如對住病人，你覺得邊一樣係最好，如果以你作爲專業人士？

A: 其實我覺得廣東話囉，最好囉，因爲佢地最容易明白，對於我自己黎講我都覺得即大部份香港既物理治療師都係中國人，咁我相信都應該係講廣東話係最容易表達既。

Q: 咁譬如你作爲一個專業人士，你覺得同同事，你覺得邊一個語言係最適合用落去同同事溝通既呢

A: 咁我諗其實都會係廣東話，因爲大家都係中國人。

Q: 咁譬如你寫一個報告呢？以現存你作爲一個物理治療師，你覺得咩野語言係比較適合少少？

A: 我諗係寫一個報告，無論係 daily record，或者係.....都係英文，因爲可能係傳統既問題。再加上上面一 D 高層人士可能有 D 未必咁識中文架。咁同埋個 system 入面，咁所以用英文會係比較好 D。

Q: 你覺得有冇一 D 作爲物理治療師同病人之間既溝通，有冇一 D 要改善既地方？

A: 係語言上？

Q: 係。

A: 其實我都幾滿意依家個情況，因爲溝通上我又會覺得除左人同人溝通得多呢，大家就會知道對方講緊 D 咩。我地見 D 病人有時都未必真係見一次半次既，咁你見多幾次，大家摸熟左知道既時候，咁大家咪容易 D 理解囉。

Q: 即你覺得依家都好滿意。

A: 係，都冇咩問題我覺得。

Q: 你覺得依家一個物理治療師，佢地個專業地位，你覺得個高低係點樣？

A: 其實同我初初讀物理治療黎講，我覺得俾大眾黎講呢個認識程度高左好多，因爲我記得我讀初初報讀既時候，大家都唔知物理治療係咩，剩係覺得係按摩。但係依家呢幾年黎，五、六年勒，五、六年倒，係大眾方面係提升左我覺得，覺得呢個係專門既，要讀既，係一個好專門既科既。咁但係我覺得係醫院入面，其實依然都係好底囉。即醫生始終係香港黎講都係一個，即係醫療界入面係一個 leader，佢係一個 leader top 住。即可能某一、兩個醫生佢會尊重你，咁佢會問下你既意見如何，但係個問題係總括黎講佢地唔係會聽囉，同埋有 D 醫生會覺得可有可冇。咁我覺得係番呢個醫院入面都係比較低一 D，即係其實都係醫生同護士，跟住其他個 D professional，都會係比較可有可冇既地位，即係有係度有陣時我地俾佢拎黎做擋箭牌囉。有陣時佢地搞黎搞去冇野搞，咁就將個波推左落黎我地度，咁個病人就煩佢地少 D，就煩我地多 D 咁解囉。

Q: 咁頭先我講既就係尊業地位啦，咁譬如係個權力方面呢，你覺得物理治療師有冇即係一個權力呢？

A: 其實真係好少呀！因爲係醫院黎講真係醫生話晒事囉。同埋亦都可能其實一樣野黎講，對於黎講佢地係比較全面 D 會知道病人個情況，我都承認呢一樣野。咁變左我地最多都只係有權做唔做個病人，個情況我地識唔識去做呢個治療。但係到最終，好似好簡單我地決定完我地唔做，但係醫生話要做，地都係要做。因爲係 D out-patient centre 我地話 DC 個 patient，但係佢可以寫番封信黎話 keep 住 treatment。咁又或者係病房我地話 query 個 patient 有 D 問題，我地唔做，可能佢跟住係排板佢直情寫 "vigorous chest physio"。咁除非你同個醫生真係傾完一大輪，咁可能佢可能接受你意見，或者唔接受意見咁樣囉。如果佢唔接受，你可能要繼續做囉，但係你可能要同佢講到明佢肯唔肯負責囉。不過係病房就會係因爲大家都驚影響多 D，咁有個 trend 就係寧願做錯不如唔好做，咁可能會搞少 D 囉有時會。

Q: 頭先係訪問既初期你都提過話有時講英文係因爲尊重個上司，或者係佢個地位係高少少，咁我想知道其實即係我地倒番轉黎睇，你會唔會覺得係講某一種語，或者方言既時候會俾到你一個比較高 D 既權威，或者係地位咁樣呢？或者首先我地從權威方面啦！

A 其實我又唔係好覺喎！因爲我又唔覺得話講英文特別好咩野，因爲香港其實好多人都識講英文啦！況且你又唔係講得好過人，即你話你講 D 好……即係我覺得太多人識講勒，我覺得唔係一 D 問題。反而我會覺得有 D 人會覺得講英文會覺自己 superior D。咁我覺得人唔係剩係睇呢 D 野既，要睇埋你行出黎個人係咪真係咁有地位。如果你做 D 野出黎俾人覺得係你根本唔係咁高尚既，你講咩英文，講幾好既英文我都覺得係冇用囉。

Q: 係，即你覺得兩者既關係唔係咁大？

A: 係。

Q: 咁但係可唔可以試下詳細解釋就係話你都會覺得有 D 人會覺得係，可唔可請你詳細解釋？

A: 其實我唔知，因爲我感覺上有 D 係街度，有 D 人會覺得講英文係即代表自己受過高 D 既教育，個人係會高尚 D，咁就會講英文，甚至乎佢地講個陣時既語氣俾你感覺到囉。但係我覺得呢樣野唔係既，即係我永遠都相信一樣野：你有料唔一定要 show 晒出黎俾人睇囉。

Q: 咁我諗今日既訪問就差唔多，到此爲止，唔該晒你先。咁你有冇咩問題想問？

A: 冇勒。

Q: 唔該晒。

Transcript 2

Q: 今日係一九九八年二月八日，訪問二。係我地開始之前，首先我要多謝你參加我地呢個研究。咁係我地做呢個訪問之前，我想有少少補充關於呢一個訪問。呢個訪問大概一個鐘頭左右啦！咁其實主要目的係加深了解你地作爲一個物理治療師，專業人士，對香港語言運用一 D 睇法，同埋係其他方面既一 D 意見。咁呢個訪問就會係會錄音，同埋將來亦會作爲研究既用途。咁係呢個訪問，如果你覺得有 D 咩問題令你覺得尷尬，你可以拒絕回答，甚至乎可以終止呢個訪問。咁係做完呢個研究之後，呢盒帶係將會被燒毀，同埋我地保證所有資料絕對保密，同埋你個名將唔會出現任何將來發表既論文，將你個名字不記名。我想問你有冇咩野問題呢？,

A: 冇。

Q: 咁我地依家開始勒！咁其實呢我想作個了解就係話，譬如係十分裏面，一分爲之最低，十分爲之最最高，即係最好。咁你覺得自己係中文個語言能力方面有幾多分呢？

A 你既意思係指廣東話？

Q: 係書寫個能力。

A 書寫個能力，我諗三、四分倒啦！

Q: 三、四分，咁如果係英文個語言能力呢？

A 英文語言能力呢，即係書寫方面？

Q: 係。

A 我諗大約有六、七分倒啦！

Q: 六、七分？

A: 係。

Q: 咁如果係講方面呢，廣東話你會俾自己幾多分呢？

A: 廣東話，我諗七、八分倒啦！

Q: 七、八分。咁英文呢？

A: 英文呀，大約都係六、七分倒啦！六、七分倒啦！

Q: 咁國語呢？

A 國語呀，大約都係五、六分倒啦！

Q: 五、六分左右。咁譬如總括黎講，中文方面你會比幾多分呢？

A: 包括埋書寫？

Q: 書寫呀、聽講呀。

A: 我諗都係五、六分倒啦！

Q: 英文個方面總括黎講，你個語言能力係幾多分呢？

A: 六分倒啦。

Q: 六分左右。

A: 係。

Q: 咁日常生活之中，你會用咩野語言比較多 D？

A: 咩野語言？廣東話囉。

Q: 咁點解會擇廣東話呢？

A: 因爲香港人全部既基本語言就係廣東話。咁用番廣東話有好多時容易表達 D，加埋係自己本地人，有時 D 特別既野都要用番廣東話黎講就會覺得親切 D。

Q: 親切 D。譬如你話特別 D，即係頭先你提到特別個字呢，可唔可以請你再詳細 D 講下？

A: 譬如有 D 時候你用英文都係點講，要好 formal 既形式同人溝通，或者呀你真係要用到翻譯左 D 英文，你可以講出黎，但係用廣東話既話，你會用所有既字眼，或者包括一 D 你會聽到既音調，你都可以同人去傾倒你真真正正所表達既意思，就會覺得係個表達既情況就會好 D，即係你會明白更加多 D。即係因爲有陣時剩係語言，有陣時你會睇埋個語調，或者睇埋人地眼神，既係諸如似類既野。但係你唔係剩係話個詞語，或者個詞彙，其實你剩係留意個樣野既時候就唔夠。

Q: 咁譬如你頭先都提到，你會比較上多 D 揀廣東話，咁會唔會一 D 特別既情形，你係一定會揀廣東話，即係你係一定會揀廣東話作爲你溝通既工具呢？

A: 有咩特別既情形？

Q: 係。

A: 冇咩特別既情形，一見到中國人就一定會講廣東話。

Q: 譬如有咩特別既情形之下，你會選用英文？

A: 用英文……咪物理治療係工作時候囉，因爲呢個其實就好耐歷史以黎都因爲英國殖民地之下呢個教育制度係英文，咁好似自己，就算你治療師係醫學入面都係用英文同人交流。如果係病人面前，即係治療師同治療師之間好多時都係會用英文交流溝通，即係因爲係表現出一個叫做 professionalism，即係一個專業囉，但係就同埋你同外國人第一口你都係用英文既囉，冇理由用中文，就係咁囉。

Q: 其實我都幾有興趣想知道點解會覺得講英文會係比較 professional 呢？

A: 唔係既，而係因爲你好明顯一樣野就係話好多時，你讀既專業個課程入面呢全部用英文既 term。英文既野時候，你冇錯，如果係私下交談既時候會用中、英文夾雜黎講既，但係你話係病人面前既時候呢，表現出用一種語言去交流既時候係好 D。同埋你就算寫落去個 D 所謂 bed note 入面時候，都係用英文既時候，基本上會係覺得一致 D，咁樣樣。咁就你話係咪一定需要有陣時都有 D 情況下會用中、英文夾雜既，但就係好少會完全用廣東話，因爲最緊要個 D term 好多時你基本上識廣東話或中文係 D 咩野就係咁囉。

Q: 咁譬如普通話呢，係咩情形你係會比較上會用普通話比較多呢？

A: 對 D 新移民，中國既人就會用普通話囉。咁但係你話其他時候就唔會用。

Q: 咁點解你會覺得同新移民你要用普通話呢？

A: 因爲個陣時佢地未必認識廣東話丫嘛。咁我梗係會用廣東話啦，但係如果佢係聽得一半半既話，我會寧願揀普通話。

Q: 咁譬如倘若有個新移民，咁你發覺佢廣東話又聽得明，普通話又聽得明，咁你會係呢個情形之下你會選用邊一種語言同佢溝通呢？

A: 普通話。

Q: 普通話？

A: 雖然我 D 普通話會係講得唔好普通話。

Q: 你係幾時會用中、英文夾雜呢？即係我意思係話，中、英文意思，可以係廣東話夾英文，或者係普通話夾英文。

A: 好多時你同你 D 同事傾計，你基本上都係要用中、英文，因爲最大問題就係話香港你既 terms，就算你係中學既時候所用既課本，大部份都係用英文。咁但係呢你溝通既時候係用中文，你覺得係最親切，但係個問題就係話你 D terms，你有陣時唔識個 terms 中文個 terms，你就會好難。你譬如你聽到我依家講 terms 呢個字，你依家要我呢一刻去譯番 terms 呢個字中文係咩既時候，我未必知。咁黎講。好容易就用中英文黎去同人溝通，黎同人傾計。

Q: 係咁譬如你講，中英文，頭先你所講中英文，個中係代表邊一種語言？

A: 廣東話。

Q: 即係廣東話同英文。即係比較上普遍就用廣東話同英文既？

A: 係勒。

Q: 咁譬如係自己個範疇入面，你覺得即係中英文夾雜其實係話一句英文入面加小小廣東話啦爲之中英夾雜，定抑或係一句中文，一句英文，即係其實你既意思係點樣樣呢？

A: 我諗係主要黎講大部份主要係中文，但某 D 既 terms 呀，某 D 既詞彙呀，會係用番英文囉，即係大部份既詮譯既意思會係用廣東話。

Q: 係，咁根據番份問卷，係屋企呢，你會比較上同父母溝通時候會用廣東話啦。咁其實可唔可以請你再詳細解釋一下呢？

A: 因爲係屋企黎講，你都會好少會遇到一 D 即係外來既 terms，即係你會好明顯，譬如你用到屋企每一樣野，或者每做一樣野，你都會知道中文個 terms，就會容易搵到囉。即係你唔會話有特別既詞彙你要運用既時候，你又諗唔到中文既詞彙係點樣用既時候，你就要用英文既詞彙咁樣樣，咁所以可以用到廣東話同屋企人溝通。

Q: 咁另外同兄弟姊妹，你都係揀廣東話，咁個原因係點解？

A: 都係個個原因。

Q: 都係個個原因，係。咁另外同同事呢，你就揀左用廣東話同英文夾雜，咁頭先都提到少少既原因，可唔可以請你，有冇其他需要再補充一下，即係點解會係呢個呢？

A: 冇咩啦，都係因爲主要係有 D 特別既 terms，根本事上唔知中文既詞彙應該用邊個既詞彙。咁就會用左英文表達個一刻我想表達既野。

Q: 係，即係其實你覺得廣東話加英文夾雜就容易 D 溝通？

A: 係，冇錯勒！

Q: 咁同波士或者上司係工作既環境之下，你都會揀廣東話同英文夾雜，個原因係點解呢？

A: 因爲都係主要原因就係話個 terms，你都係 D 有野，你係需要用到個英文個詞彙至可以表達到你既意思，就係咁囉。

Q: 係。

A: 但你就話，呢間唔中呢因爲有陣時因爲波士係有 D 鬼佬黎，即係 D 外國人黎既，個陣時要用番英文囉。雖然物理治療師，係香港既物理治療師要全部識講廣東話既，但你會覺得尊重番佢既時候，你會用英文同佢講野先。但佢有陣時，佢亦都會用廣東話講番一、兩句。

Q: 咁你所提到因爲想尊重番佢。咁可唔可以即係話選擇用英文同佢講就尊重番佢，可唔可以請你再詳細 D 講下即點解揀英文就會感覺上會係尊重佢呢？

A: 因爲我覺得就係話，譬如佢一個外國人既時候，我又識得講第二種語言既時候，咁我就係尊重佢既時候，我用番你既英文，咁你好明顯就係，佢都會即係同你講番一、兩句既時候，佢亦都會用番中文去同你講時候，其實佢都覺得應該尊重番你意思既時候，佢都會用番一 D 中文黎同你傾，但個陣時就唔會話中英夾雜架啦，就會全英文或者全中文，或者某 D 係廣東話時候會有少少 terms 係會用番英文既，既係就咁樣樣囉。

Q: 係。咁同朋友係一個譬如 social gathering 咁啦，你都係會用廣東話同英文夾雜啦，其實係點解呢？

A: 其實就我諗最主要係依家會覺得親切 D 囉咁樣囉，如果你剩係用廣東話既時候，你就會覺得即係你會覺得呀好怪，個種感覺係好……好木個種感覺，即係好怪，你完全覺得唔投入咁。但係你個個都英文既詞彙呀，又用 D 中文既助語詞，又加 D 英文既助語詞，就會即會覺得好似好似好暢順，好親切咁樣樣。

Q: 咁另外同病人，係做治療既時候呢你都係揀左廣東話同英文既夾雜，有冇特別既原因呢？

A: 其實我地都盡量都係用廣東話既勒，但係好難有一樣野就係話我地用，盡量用中文解釋左，但有 D 特別既 terms，你都係依然係有時你記唔到個 terms，你會用一 D body language，即係你用 D 指住既地方，跟住就話「就有 D 咁既野，我地呢就會譬如話我會用一個英文字，呢 D 我地英文就叫做 scar」。譬如話個 scar，

但係你有陣時因爲你讀慣英文係叫 scar 呢樣野既時候呢，你就話「呢度有個 scar」，咁樣解釋比佢聽，即係 within「咁樣係個咁樣位置」，係用中英文去溝通。因爲有陣時你好難會將一刻你讀左咁多書既英文既 terms 轉做中文既，你好難既，所以我都係用解釋，就係話我用中用英咁去同病人溝通。

Q: 咁其實呢你覺得你係同病人溝通個時有冇一個困難既地方呢？

A: 困難呀，我諗其實大部份都冇咩困難，因爲香港人大部份都係係中英文既學校出身，即係中英文都會識既啦！但你有 D 深既字，佢咪記住囉，即佢未必知道個字點串，但係佢就記住咁個發音，佢就係代表呢樣野。咁即係香港人不嬲都係咁樣樣，咁但係就我諗困難既就係話譬如同 D 比較年紀大，或者唔識英文個 D，咁你咪呀用 D'body language，用 D 好複雜但亦都又盡量簡單咁去解釋比佢聽之後，佢明左啦，就算架啦。即係唔會再仔細 D 同佢再講番個譬如話你依家邊到受傷呀，個問題係邊呀，咁我地好難會再詳細去說明一 D 野，即係會有困難。但如果你話對於一般普羅大眾既香港人黎講就係中、英文夾雜係冇咩大問題既。即佢地亦都會識得一、兩句英文囉。D terms 未必識得，但係就佢聽到之後，佢會覺得記左個 terms，佢會覺得知道少少個問題係邊囉。但就未必會係完全清楚個 terms 點解，但就係佢地覺得，我覺得佢地會知道多D既時候會舒服D。

Q: 咁其實你覺得物理治療師同病人溝通呢，即係作爲一個物理治療師，重唔重要呢樣野？

A: 好重要架，因爲有個問題就係話，同病人溝通既話你會觀察到好多野，同埋亦都最大問題就係話，佢係咩問題要由佢話俾你聽，跟住你亦都要從佢話比你聽既問題當中你再分析佢究竟係有D咩問題。即係佢只可以話到俾你聽佢邊到痛咩問題，咁但係我地就係透過我地聽得出既時候，我地再要或者再加埋我地既專業既評估，加埋檢查就可以知道佢發生邊個……即係結構上有問題既時候，我地就可以更加進一步解釋比佢聽你既治療係 D 咩野野，究竟要點樣去幫佢，做 D 咩運動，即係呢 D 咁樣樣，我地既溝通係好重要。

Q: 咁譬如係依家香港個語言制度就係廣東話，英文同普通話三樣野可以叫做同步用緊，咁可能當然主次，或者係重要性有所唔同。咁其實你對於呢一個現全個語言制度呢，你有 D 咩意見或者睇法呢？

A: 有咩意見，有咩睇法。我諗其實最大問題就係話呀我地基本上溝通既時候用廣東話，但係讀書或者一 D 我地學習既時候呢，主要黎講，係以我既時代，我就用英文，因爲所有 D 書呀、課本呀都係用英文既。咁令到你有個困難就係話，你要表達既時候呢你就會用廣東話去表達自己內心既感受個 D 咁既野。但係就去到一 D 詞彙既時候呢，就用番英文，同埋有好多時候呢因爲你睇書你學左個 D 我地所謂 sentence structure 個 D 英文，跟住呢你

就好容易呢，你第 D 時間你一諗既時候個 sentence structure 就咁就出左黎勒。你有陣時寫文件都係，寫中文個時候就變左用英文既 sentence structure 變番做中文，咁變左係好唔通順，但有個問題就係話呀，我地講既廣州話又唔可以即刻書寫出黎，又要去番譯成爲國語，即係普通話啦，咁至可以寫出黎，換言之黎講，我地香港人面對緊一個問題，就係語言個表達可能就係講野可以做到，但係你話書寫個方面，我覺得會係比較差 D。因此主要原因就係話主要書寫個兩種語文都唔係我地既基本既談話既主要語言囉。

Q: 係。同英文好唔同，英文寫，講得出通常都寫得番出黎。咁譬如你將呢個情景，你即係套用番依家呢個醫療架構入面，你覺得即係你會唔會有咩野睇法呢？對於依家現存既語言制度，咁搬番落我地現存既醫療架構入面，你覺得有冇咩野影響，或者係你點睇囉？

A: 我覺得影響通常都，唔係好大既，因爲其實係語言架構方面有個，有樣野就係話……大致上我覺個問題唔大既，因爲始終寫落 bed notes 既時候，就係用英文，而英文就係用 point form。Point form 既時候就會係令到好多人會好容易明白，亦都好快咁去明白，咁所以我覺得個問題就唔係太大既，因爲你一望就知佢講 D 咩野，但係就我諗一個溝通真係個問題唔係太，反而係如果要寫篇比較你會你覺得好 D 既文章既時候，可能好多治療師都覺得有 D……驚。因爲我覺得好多情況下我地真係要用番一篇語文，去寫番一篇文既時候，好多時都會覺得頭痛，就係要坐埋一邊慢慢寫番，至夠膽去即係個篇文章去見人囉。或者所謂見人就係俾其他人睇。譬如就算係我寫，寫慣同醫生寫既信我都係用 point form，咁就會覺得冇問題。但係如果你要我打一份 report 既時候呢，我都要幾長時間去諗一諗 D 字睇眼呀應該點樣運用呀咁樣囉。

Q: 你地所謂驚呀，即係頭先你話所謂驚，同埋要見人，個問題出係邊呢你覺得？

A: 我覺得就係話，基本上係譬如寫中文既時候，你基本上你都好少運用咁既詞語組織呀，句子組織呀。咁去寫既時候，基本上你會覺得習慣，雖然你話你自己某有一 D 定既中文水平，你譬如你睇報紙既時候，都用左中文睇報紙，但係會發覺自己寫篇中文報紙個語言結構呢係有 D 問題。咁至於你話寫英文既時候咁就個問題就唔係太大既。即係會可以做到好多表達到既野，但係始終就係話呀你會覺得寫英文既時候，好多時你係咪表達到我想用廣東話講到既野囉，或者有 D terms，你分分鐘真係你表達唔到既。或者你唔係一 D 所謂既專業詞彙，而係話有 D 字眼，譬如話個阿婆痛成點，未必 describe 到俾佢聽，既係你係語文上咁個陣時係個問題。

Q: 咁譬如你自己作爲一個專業人士，一個物理治療師，你覺得最適既語言，最好既語言同病人溝通，係同病人溝通你會揀邊一種語言呢？

A: 香港黎講，用廣東話。

Q: 咁如果同同事呢，你作爲一位專業人士，你覺得用邊一種語言係最適合呢係香港入面？

A: 廣東話加英文，少少既英文。

Q: 係。咁你覺得有冇咩野需要改善呢，依家係物理治療師同病人既溝通之間？

A: 要改善既！因爲我諗我覺得個問題依家黎講都唔係咁大，因爲始終都係大家溝通倒。但係你話個問題係你始終變左係用三種語，即係二種語言去，其實咪三種——廣東話、同埋英文、加埋你要書寫既中文，普通話，即係呢三種，二種語言，一種方言。咁就令到佢變得更加複雜。但係就覺得就係話除非你就一係就搵一個階段，你去 out 一種語言，或者係你真係將廣東話轉哂做普通話，然之後再用普通話溝通。我地有三種溝通既方式，但係我地最常用既方式係廣東話加英文，咁係會令到我地最好既溝通方式。但係最大問題就係話書寫，就唔可以咁樣囉。但係有陣時你會見到譬如你 D 同朋友書寫，書信既時候，就算你寄去外國，你都會番一 D 廣東話加英文個種書寫方式既時候，你就會覺得大家好明白大家，係好唔同。但係就如果你以一個正式既文章或者報告既時候，你唔可以咁做既時候，你就會出左問題。

Q: 咁譬如我地拉番開少少啦，你覺得係呢個語言同個對象，說話既對象，你覺得有冇咩野關係呢？

A: 中國人你會揀番廣東話或者中文啦；外國人你會用番英文啦；就你同事你想表達完全 D，或者同其他專業人士，譬如 D 醫生既、護士既話，你都可以用中、英文啦。即係呢 D 一定既啦，因爲你知道點樣至會係真係可以大家完全溝通到既時候，你就會用 D 咁既詞彙，有 D 特別既 terms，譬如 D professional terms 既時候，其他既人未必知道個中文詞彙係 D 咩野既時候，你反而你就要你可能會再問番你既，你就不如要用英文 terms，即係大家都知道既 terms，反而會好 D。

Q: 其實我最想了解就係話你覺得語言既選擇同對象，佢兩者之間既關係，你覺得係邊一度呀？

A: 你再問多一次。

Q: 即係話，譬如你揀邊種語言去溝通，同埋你會同邊個人去講野呢，你覺得兩者有冇關係，即係會唔會話，即係頭先都提過，可能話對醫生或者對護士，可能會講左中、英文夾雜，咁可唔可以你再具體一 D，再宏觀一 D 解釋一下呢兩者之間既關係呀？

A: 關係其實就好明白一樣就係話你見到個人係咩野人既時候你就會有種關係，你知道佢講咩話囉，就係咁之嗎！

Q: 其實可唔可以或者我試下解釋，或者我唔正確，你試下更正我，其實你意思係唔係就係話呀，如果個人係會係佢係咩職業呀或者同你之間個工作性質既關係，一 D 朋友性既關係，咁樣呢你就會好自然抽出一 D 你認爲同朋友溝通應該用既語言，同同事應該溝通用既語言，會唔會係咁呢？

A: 可以咁講。

Q: 咁譬如地點呢，你覺得會唔會係唔同既地點，你就會揀唔既語言呢？

A: 都唔會既。主要係個情況，除非你突然間個地點，譬如係病房入面，通常都會用番英文既，即係話通常用番英文就係話我地睇緊 bed notes，睇完 bed notes 既時候我再同同事一齊傾個 bed notes 既內容既時候一定會用英文。你可以話個傳統已經係咁樣去做開既睇完 bed notes，係病人面前會用番英文同同事去傾番呢個問題。

Q: 咁譬如我想了解一下會唔會同一個對象你係唔同既地點講野既時候選用唔同既語言呢，有冇咁既情形？

A: 好少。

Q: 咁譬如係語言同題材呢？即係譬如話我傾某一 D 既 topic 既時候我就會選用其他語言？

A: 冇，同題材都冇關。

Q: 咁譬如你覺得呢四者其實個語言既選擇，對象、人物、地點，你覺得佢地之間個關係，有冇一個密切 D 既關係呢？

A: 同人會有啦！地點我覺得冇咩。題材都冇咩。

Q: 係。咁你覺得呀依家香港物理治療師呢佢係香港作爲一個專業人士，佢個權威性，你覺有幾多呢？

A: 權威性，我諗佢都幾高既，因爲始終物理治療師係某一個程度方面幫倒班病人呀，但係就係個架構方面或者係個制度方面，始終個地位都唔係實在太高囉。

Q: 咁你覺得個程度係幾多呢？

A: 程度都幾緊要下。係市民心目中物理治療師係一個好高地位既人，即都算幾，唔係好高啦，但係係一個醫療架構入面呢，物理治療師實在唔係太高囉。

Q: 譬如係高中低呀，你覺得屬於邊個層次呀？

A: 我諗係屬於低至中倒啦！

Q: 係，兩者之間徘徊啦？

A: 係。但如果係市民黎講，物理治療師既地位算係高啦！

Q: 咁其實你覺得點解呢？即點解會係市民方面就會權威性比較高？但係反而係個醫療架構入面會相差咁大呢？

A: 因爲係市民方面我地真係做到 D 野幫倒班市民囉，即係佢地有問題既時候，我地真係幫倒佢地，幫佢地治療倒譬如呀某一程度方面既問題。但係係醫療架構入面始終個制度入面，物理治療師係香港，第一，人數少；第二個地方係少，就算你睇番個入職表黎講，香港既物理治療師都係比其他既入職點，其他治療師或者唔可以話其他治療師，其他一 D 我地所謂大學畢業既人士既入職點係低囉。咁呢樣野我覺得對於我地個地位係有影響，因爲個架構係咁大既時候，佢有咁多既人工黎做，你係屬於幾高級既員工既時候，因爲物理治療師個入職點低，同埋就算你既人工比較低既時候，佢會覺得你只係一個好普通既員工黎，即係唔會唔覺得你係一個好專業既員工，譬如對於某 D 譬如話呀醫生個人工可以去到好高既人工。咁呢樣野係差一段距離，同外國個比較真係好唔同，外國既治療師同醫生 D 人工係差唔多。

Q: 咁譬如你覺得個權力呢，即係作爲一個物理治療師既權力係一個個醫療架構入面，或者係同病人你覺得有幾多呀？

A: 香港個，因爲制度影響下，個權力係好特別。因爲始終個香港個 referral system 同外國好唔同，外國既話，病人可以直接黎搵我地，我地係需要醫生既轉介。咁呢樣係對於我地物理治療師黎講，我覺得係好唔公平既一樣野黎，但係就始終呢個制度依家已經成定案，我地要跟進既話，會影響我地個專業，因爲專業其中一樣野係叫做，要有一樣個 criteria 係要有 autonomy 係主宰係醫生度，呢個係個最大問題囉。

Q: 咁但係譬如你覺得你作爲一個物理治療師係呢個決定權，自己譬如做一 D treatment 個決定權，你覺得有幾多呀？

A: Treatment 個決定權，好多既……以我地揀番譬如佢指赤痛勒，依家 D 醫生都會尊重番我地，唔會話譬如你要做 B，就 B 呀。通常話物理治療，please。佢都會話番俾你聽，就係話做番你覺得邊一樣既 physiotherapy。同幾年前好唔同，幾年前 D 醫生直頭會話做邊樣，邊樣既物理治療既 method，佢會咁樣同你講埋添！但依家就好左好多囉，依家話"physiotherapy，please"咁樣囉。

Q: 咁譬你覺得會唔會呢，係選擇某一種語言或者方言同你既病溝通既時候呢，會係俾你一 D 高 D 既權力呢？或者係影響力呢？

A: 唔會！語言影響唔到，因爲始終語言其係話以前就話好似話 D……我諗以前都係睇膚色黎講，唔係睇邊種語言既，你以前始終係英國殖民既話，D 外國人係所謂英國既人特別 protective，會高 D 地位，但係依家已經，回復番中國既時候，其實我覺得個分別唔大囉。

Q: 咁呢，譬如我作一個比較假設性既問題，你會唔會覺得一個物理治療師，佢剩係識講譬如廣東話，一個剩係識講英文，同埋一個剩係識講國語既，我講中國人物理治療師，你覺得係佢地個專業地位或者專業權力上有冇一個分別既？

A　地位冇分別，但係我覺得個實際上有問題，就係話英文同埋個識國語既物理治療師只會做到，幫到香港既某一部分既市民，而廣東話個個就會幫到大剖分既市民。

Q:　係。咁係我份問卷入面呢我仲有幾條問題都想再佢深入少少既了解。咁就關乎你點睇個香港物理治療師個權威呀。咁你會覺得病人都應該遵從我個指示或者意見咁。咁其實你點解有咁既睇法？

A:　因爲我覺得我有個專業意見叫你咁做既時候，你黎搵我幫你既時候，你就應該跟從我個方式去幫你，因爲我係比你係物物理治療方面係知多 D 去幫你，如果你唔跟從我既意思既時候咁點解你黎搵我？即係呢個係最大個點解會咁樣去選擇既原因。

Q:　係。咁重有另外一條呢就係，當唔係好同意我個病人既意見既時候，咁我通常會嘗試去改變病人既意見，咁你就話 neutral，其實可唔可以請你再詳細 D 解釋一下呢？

A:　我始終覺得就係話佢有個意見既時候同我唔同，我已經解釋左，我亦都唔會游說佢囉，即係我只會話我講我既意見，你有你既意見既時候，O.K. ，咁就睇下你肯唔肯跟我既做法囉。如果你唔肯既話，我亦都唔會 insist。跟住我就會話我亦都唔幫佢所要求個方法，我只可以話咁我幫唔倒你。我唔會話 insist 去說服佢，我覺得冇咁既必要囉。即係佢鍾意，佢有佢自己既睇法，我有我自己既睇法既時候，就大家都唔干涉大家，最多係我幫唔倒你！

Q:　咁今日既訪問差唔多，唔該晒你！

A:　唔駁客氣。

Transcript 3

Q: 一九九八年二月十號，訪問三係我地開始之前，首先我想多謝你就參加我地呢個訪問。其實就有少少我想補充既。咁呢個訪問大概會係一個鐘頭左右，咁我地就希望藉住呢個訪問可以深入 D 去了解你作爲一個專業人士，即係對香港依家既語言個情況既一 D 意見，同埋係一 D 其他方面既一 D 評價或者係意見既。咁呢個訪問將會係錄音，同埋將來亦都會作爲呢個研究既資料既。我地會保證呢 D 資料係會絕對保密啦，同埋你係會以不記名既形式作爲我地既被訪者既。呢 D 帶就會係完成個研究工作之後就會燒毀既。咁如果係呢個訪問期間有 D 咩野問題你覺得尷尬或者係引起你不安，你可以隨時拒絕回答呢個問題啦，甚至乎就係終止訪問都可以既。咁你有無咩問題呢？

A: 無呀！

Q: 咁我地依家開始勒！咁譬如係十分人入面，一分係最低既，十分係最高既，咁你認爲自己係中文個言語能力總括黎講，你會俾幾多分呢？

A: 七、八分倒啦！

Q: 咁如果係英文個言語能力，你總括黎講會俾幾多分呢？

A: 都係差唔多，七、八分。

Q: 都係七、八分。咁譬如我地再仔細 D 深入去睇下，咁譬如係書寫中文個方面你會俾自己幾多分呢？

A: 書寫呀？Formal 定 informal 呀？

Q: Formal 丫！

A: Formal，formal 可能五、六分啦！

Q: 咁如果係英文書寫係方面呢？

A: 六、七分啦！

Q: 咁另外講開即係講個方面，如果廣東話，你俾自己會俾幾多分呢？

A: 廣東話，七、八分啦！

Q: 咁英文呢？你會俾自己幾多分？

A: 一樣啦！

Q: 都係七、八分。咁普通話呢？

A: 普通話……九分。

Q: 咁係日常生之中呢，你會通常用邊一種語言會比較多 D 呢？

A: 日常生活呀？

Q: 係。

A: 廣東話啦！

Q: 咁其實有 D 咩情況之下，即係你會特別係一定係選擇廣東話爲你所用既語言呢？

A: 如果個個人，即係多數 D 人剩係明廣東話啦，其他個 D 就唔係好明啦，咁所以我就會揀廣東話勒。

Q: 咁譬如英文呢？有 D 咩情形之下你會用到英文作爲溝通呢？

A: 同 D 唔識講中文既人就會用英文。當然佢地都要識啦。

Q: 咁呢個係你唯一原因？即如果佢地係唔識廣東話或者其他，唯一識英文你就會用英文去溝通勒？

A: 唔。

Q: 普通話呢？咩情形之下你會揀普通話同人溝通呢？

A: 如果個個人明白呢，即係普通話，講佢又講倒既，我就會用普通話，唔會用廣東話，亦唔會用英文架勒！

Q: 點解呢？

A: 點解呀……因爲可以話係 first language，即係第一語言，即係一學講野就先講普通話先，就覺得比較流利，容易用。

Q: 係。咁譬如你係你日常生活之中，你有冇會用到廣東話同英文夾雜，或者係普通話，即其實係兩種語言咁樣夾雜，即中、英文夾雜？

A: 我諗我通常會夾廣東話同國語夾雜多 D，英文就少 D。

Q: 係，點解呢？

A: 如果日常生活通常係屋企，就有 D 字眼突然唔記得左廣東話點樣講可能就要用國語代替，又或者係講到國語唔知點解順口就會講左廣東話既。如果係講就會兩樣 mix 左，可能有時都唔覺。

Q: 咁其實你話「唔知點解」、「唔覺」丫，其實如果你再諗深一層，有冇一 D 原因會令你覺得會用到咁樣夾雜語言呢？

A: 可我阿媽，多數都係我阿媽會聽得清楚 D、明白 D！

Q: 即你指夾雜……

A: 夾雜國語同廣東話。

Q: 佢就會聽得比較清楚 D？

A: 係勒。

Q: 咁頭先你都提到，你都會同媽咪用廣東話同國語既夾雜啦，咁呢個你覺得係咪最通常同你媽咪溝通既工具呀？

A: 唔係既，一係就廣東話，一係呢就國語。即係間中就有 D 夾雜既情形。

Q: 咁邊個最普遍 D 呢？即係最多？譬如剩係廣東話比較多呀？剩係國語，即係你頭先提到個三種，邊種係比較普遍 D 呀？

A: 我諗國語同廣東話一樣一半。

Q: 點解你揀呢種語言同你父母溝通呢？

A: 因爲呢兩個語言係佢地最清楚明白架啦！

Q: 係。會唔會有冇話係唔同既地方，即係譬如係屋咁就會用同係街出面既唔同呢？

A: 邊方面呀？

Q: 譬如你同父母係屋企就用廣東話同普通話每樣一半一半咁樣呢。咁譬如去到其他地方，你會唔會改變呢個模式？

A: 就都係視乎睇下對方識得聽邊一種說話勒我就會揀邊一種。

Q: 倘若你仍然同你爹 D 媽咪一齊既，但係只不過唔係屋企，去左

其他地方，會唔會有改變語言個出現？

A: 我諗都會差唔多，不過可能廣東話會比較多少少。

Q: 點解呢？

A: 點解呀……因爲如果係有其他人在場，咁講廣東話好多時佢地會明白，咁我就會揀廣東話，咁就唔駛話再重覆一次。除非係有 D 字眼可我媽唔明，就用國語講俾佢聽，等佢明白咁樣。

Q: 咁譬如係題材方面會唔會如困係因爲題材而影響到你係語言選擇有所不同呢？

A: 點樣話？

Q: 即譬如個題材，你講開一個話題，咁而轉去另外一個話題，會唔會因此而令你改變左你揀邊一種語言去同你爹 D 媽咪係屋企講野咁樣呢？

A: 應該都唔會既！

Q: 即冇咩大影響？

A: 係。

Q: 咁譬如你同你 D 兄弟姊妹呢？你通常會揀邊一種語言比較多 D 架？

A 我諗我三種都有啦！英文、國語、廣東話三種。

Q: 但係你所謂呢「三種」，係獨立咁分開，定抑或都會有呢種混合左黎用咁樣？

A: 好少混合，多數都係分開。一係就講哂肆但一種。

Q: 咁最普遍既，你通常同細佬用邊一種語言比較多 D？

A: 我諗廣東話啦！

Q: 即係比較最多既？

A: 係。

Q: 點解呢？

A: 我諗係習慣啦！

Q: 咁係問卷個度呢，你就提到你同同事通常中、英，即廣東話同英文夾雜啦，其實背後既原因係咩野呀？

A: 咁其實多數呢都係用廣東話既，英文只係有 D 特別名詞呢我地唔識得中文係 D 咩野，或者諗唔起正確既中文名稱就會用英文勒。如果唔係呢，我諗個對話入面，九十 percent 都係廣東話。

Q: 點解會用廣東話加少少英文字咁樣？

A: 因爲我都話啦，有 D 可能我地討論病人個 D 情形，有 D 病既名稱係大家因爲讀書個陣時都係用英文既，所以就會熟悉 D，所以就會用英文既名，就唔會話臨時臨急去諗個中文係咩呢！

Q: 其實係你個定義入面，譬如中文加少少英文字，。對於你黎講，你覺唔覺得係一種混合語言呢？

A: 少少啦！

Q: 譬如就咁講到混合語言，你認爲點樣先爲至一個夾雜語言呢？

A: 我諗有 D 人，D 竹星呀，個類咁既人就會差唔多佢講既說話入面一半係英文，一半係廣東話，。或者其他既語文，我就覺得一種混雜既。如果係一、兩個名詞都唔算既，我覺得。

Q: 咁係問卷個度你就提到你同你上司都係用廣東話同英文夾雜，咁又有冇咩野特別原因？

A: 因爲我個上司就係受英文教育既，咁佢既中文就一般啦，即日常個 D 既廣東話，中文就 O.K. ，但係我感覺上佢既英文流利過中文。

Q: 咁所以你就揀左夾雜兩方面？

A 係勒。

Q: 另外講到同朋友，你就係 social gathering 你就會用廣東話、英文同普通話三種混合。咁其實點解呢？

A: 因爲依家好多人都識好多種語言，咁你識既朋友有唔同既人丫麻，咁唔同既人，佢明白唔同既語，咪用唔同既說話羅。

Q: 同病人呢？咁同病人你就係揀淨係純廣東話，咁個原因係邊一度呀？

A: 我諗病人多數都係佢即係佢既第一語言都係廣東話啦，變左你講廣東話佢容易明白。

Q: 咁其實依家好多病人佢可能其實都識中文同英文啦。我唔敢講話佢地既能力係一樣，即係廣東話同英文。咁其實點解你都係以揀左用廣東話爲主呢？

A: 因爲如果我用英文既話，佢地未必明白，因爲好多醫學上既名詞，普通人就未必識勒。就算佢英文好叻既話，都可能未必識，所以全部用晒廣東話。

Q: 係。咁其實你認爲係呢個揀邊種語言，同人物、同對象你覺得兩者之間有冇一 D 既關係呀？

A: 語言同人物之間？

Q: 係。

A: 我諗要視乎個人明白邊種語言，我就用邊一種語言同佢講。

Q: 咁係個語言選擇同地點呀，即你係邊一個場合講野，你覺得兩者之間有冇咩關係呀？

A: 語言同地點……我諗都有既。譬如如果我去到外國既，咁我冇理由講廣東話，咁人地就唔明。如果係中國人既地方明中文我就會用晒中文羅。

Q: 係呢個題材，不過你頭先可能都提過題材，即係你講 D 咩話題，同你用邊一種語言，你覺得兩者之間……

A: 有咩關係？

Q: 係。如果倘若話呢幾樣野加埋一齊，即講邊一種語言，又要顧及人物、地點、同埋題材，你覺得佢地三者之間關係點樣呀？

A: 顧及人物、地點、時間呀……我諗如果係咁樣既話呢就會廣東話同英文混合就可能即係唔同人既人就會明白 D 羅。

Q: 對於依家，或者我地可以扯開少少個話題，就係你覺得現存香港語言制度，你對佢有 D 咩評價，或者係意見呀？

A: 睇下佢係 D 咩學校讀書啦。咁如果間學校注重訓練佢英文方面既能力，個 D 人既英文水準就比較好，就中文差 D。如果個間學校即係一般既話呢，我就覺得佢，即係唔好理佢差唔差先，就中文水準就應該好過英文既水準。但係當然啦，呢個「好過」既意思即係話可能未必中文都一定咁好既。

Q: 咁其實你覺得依家個教育制度又會用英文，又會用中文，甚至乎依家近幾年再加用廣東話，你覺得對於一個學生黎講，有 D 咩野影響呀其實？

A 我覺得始終英文係一個國際性語言，普通話呢我就覺得應該係一個附加既，咁你就唔應該用普通話上堂。即係學生好似同聽英文一樣都係矇查查既，唔知你講咩野。咁所以我覺得如果你真係要母語教育就應該用廣東話，咁英文就用番英文黎教。

Q: 咁你覺得一個小朋友經常性要接觸呢三樣，即其實係兩種語言加一種方言就係廣東話，英文同埋普通話，咁其實覺得對一個細路仔係佢學習過程入面，你覺得會唔會太繁複要三種語言一齊並用。

A: 你指既係上堂既時候定係咩呀？

Q: 即係作爲教育啦，即係作爲教育既時候，你覺得有冇一個影響呢？

A: 我諗應該冇影響既，即好似話你有一堂專門教國語既，或者係抽幾堂係教國語，咁樣黎分開就應該冇問題。

Q: 係。咁講番起醫療界入面，咁譬如你覺得依家係醫療界入面好多時都會用到中文、英文。係說話既時候呢就係廣東話、英文同普通話，你覺得係溝通上有冇一 D 既影響？

A: 我諗呢，個主流呢都係如果你開一 D 國際性既會議呢，就冇得講架勒全世界人，即冇可能話講完黎句說話翻譯既。咁如果你話係一 D 唔係咁正式既場合入面，你可能會用少少廣東話，夾雜一 D 英文，即如果對香港人黎講，咁我諗佢就會習慣呢種咁既方式。

Q: 係。咁你頭先提到個字眼就係「唔係咁 formal 丫」。咁其實你覺得會唔會英文佢個語言地位同廣東言或者係國語有所不同呢？

A: 如果係香港黎講我就覺得兩樣都應該平等，唔可以話肆憚忽視一樣野。

Q: 點解呢？

A: 因爲你要保持呢個競爭力，你一定要識架嘛英文。咁你冇理由完全唔識你去開國際會議，就坐係度，好似傻瓜咁羅！

Q: 咁但係點解即係你話既然係咁，咁點解唔剩係用英文呢？

A: 咁你係中國人黎架嘛！咁你自己既語言冇理由唔識架嘛。咁所以一定要識。

Q: 咁其實你覺得作爲一個物理治療師，你覺得同病人既溝通重唔重要呢？即係一個 health care setting 入面，你覺得重唔重要？

A: 哦，好重要呀！

Q: 點解呢？

A: 因爲呢物理治療師就唔係好多人識，咁變左佢黎到佢唔知道自己應該期望 D 咩野，唔知應該做 D 咩野，咁所以你同佢既溝通，即係話要解釋得好清楚，佢黎呢度係爲左 D 咩野，咁我可以幫倒佢 D 咩野啦，咁然之後我地水又期望佢應該係點樣幫自己啦，咁所以其實個溝通係好重要既。

Q: 咁即係總括黎講你覺得同病人個溝通主要係用黎作爲同佢地作一 D 解釋，亦都從佢地得到一 D 佢地既需要呀、或者係佢地關心既事物，即佢地黎呢度做治療既時候。

A: 係。

Q: 咁其實你作爲一個專業人士，作爲一個物理治療師，你覺得同病人講既語言，邊一種係最好呀？

A 唔……

Q: 最適合，最好既？

A: 我諗你最好識晒多樣野，咁黎到唔同既人，你就同佢講佢唔同既說話，咁個病人一定好鍾意，即又好清楚，又好明白，唔會有誤解既。

Q: 咁可唔可以請你再詳細 D 講，你會點樣去揀呢？即譬如你三種都識，你會點樣去揀我究竟同你用邊一種語言呢？

A: 我視乎睇下如果有 D 病人係廣東話好流利既，佢本身係講廣東話，咁我會同佢講廣東話。但係如果病人呢就係廣東話唔係好得，就國語好既，或者英文得既，咁我就肆憚揀一樣野，即揀另外一個語言。

Q: 即其實你最重要，揀邊一種語言係視乎佢邊樣野明白得多 D 既？

A: 唔。

Q: 咁譬如同同事呢？你覺得邊一種語言係最好既溝通既工具呢？

A: 我諗廣東話啦！因爲日常都係用到架啦！你睇電視、聽收音機，全部周圍都係 D 人講既說話都係廣東話，咁所以就會大家容易 D 明白。

Q: 咁但係依家寫個報告，即係關於病人個 progress 咁，你覺得邊一種語言係最適合呀？

A 英文啦！

Q: 點解呢？

A: 因爲依家呢就唔同左，有 D 病人可能會去第二度工幹，移民啦，諸如此類。咁好可能佢地會要求你拎病歷既。當你 D 病歷係中文既話，佢拎黎都冇意思，因爲拎到去外國，人地都唔明白，亦都唔知你做咩。但係如果你用英文既話，咁佢拎去個邊，咁 D 醫生睇完知道，之後就知道佢係香港做 D 咩，個進展點樣，依家係咩情形，咁就可[以繼續幫佢。

Q: 係。其實你覺得係依家物理治療師同病人既溝通有有一 D 需要改善既地方呀？

A: 我諗有啦！因爲就依家治療對病人既人數既比例呢就好高既，即係話，你可能一個治療師要對成十幾二十個既。咁變左你對佢每一個時間就好短，咁就唔可以話用好多時間慢慢去同佢解釋，慢慢溝通，咁變左個關係都唔一定係咁好，可能中間有誤會添！

Q: 你所講既誤會係指邊一方面呀？

A: 譬如你同佢溝通既時間不足呢，咁佢可能覺得你唔理佢，或者忽視佢咁樣，而佢黎呢度接受治療就覺得係有不滿意呀！咁呢就佢可能有怨言，或者甚至乎嚴重 D 佢可能會走去投訴咁。

Q: 咁除左時間，譬如即係資源問題啦，即人力資源問題啦，咁你覺得重有冇其他需要改善既地方？

A: 都有既。咁其實呢就你做一個治療師，你唔係話淨係識 D 專業既野就得，就夠，其實要照顧晒佢個心理。好多時呢，病人，睇下你即係可能住醫院長，長時間住院個心理都唔同既。咁變左你如果唔能夠去適應佢個種心理，即係你唔可以有 D 咁既知識去了解佢多一 D 呢，你可能對呢個病人都會產生厭惡！即唔想睬佢。所以都要呢個知識架，咁樣可以幫倒！

Q: 係。咁你覺得語言有冇成爲你同病人溝通既障礙呢？

A 好少，除左係 D 阿婆啦！D 阿婆有 D 可能淨係識聽台山話，識得講福建話，咁就冇計勒，咁就要身邊一定有個人明白既呢，就翻譯番俾佢聽咁先至得。

Q: 係。咁譬如國語可以講話係你既母語，咁你覺得依家香港普遍物理治療師佢地廣東話既流利程度係點呀？

A: 我諗多數都好好啦。

Q: 你認爲其他物理治療師會唔會係同其他病人溝通係因語言而出現左障礙呢？

A: 我諗都可能會有架！可能有 D 治療師佢本身黎講識英文，但佢個口語，即係講呢，講唔好。咁如果佢幫 D，即係病人係外國人呀，或者係唔識廣東話，或者係唔識國語既病人就有 D 困難。

Q: 你意思係指個物理治療師係英文，口講個方面反而會係冇咁流利？

A: 係，國語都係啦，一樣啦！即如果你唔識講呢二樣野都係麻煩既！

Q: 咁其實你自己係學校學個課程呢就用英文架啦，咁你對大部份病人即係講廣東話比較多 D 呀？

A: 係。

Q: 咁有冇有陣時要解釋番俾佢聽，或者俾一 D advice 佢地會唔會有困難既地方呢？

A 俾 D 咩佢話？

Q: 俾 D advice 或者係俾 D 解釋佢地會唔會有 D 困難呢？

A: 間中啦，好少。

Q: 即係呢個情況你覺得唔普遍既？

A: 唔。

Q: 即對於你黎講你覺得都唔係有咩大問題？

A: 唔。

Q: 另外呢其實我都想了解下你覺得香港既物理治療師佢係香港既醫療架構入面，你覺得佢個權力係點樣？

A: 個權力呀……邊一種權力先？

Q: 我係指 social power。

A 我諗佢就唔係好有權力勒！因爲你醫院入面個主流都係醫生、護士，即係呢兩種人係最多既。咁當你個人數比較少個陣時，即係相對黎講你既地位就低 D 啦！

Q: 咁其實你覺得會唔會講某一種語言既時候會令你個權力比較提高少少呢？

A: 我諗係講英文勒。

Q: 點解呢？

A: 因爲香港始終都係一個國際性既社會，即係如果英文唔得流利既話都係一個障礙黎既。譬如你經常要接觸班外國人，或者係你要經常接觸，即係同外面 D 醫生、或者其他醫療人員溝通個陣時，呢個係一個好重要既工具黎既。咁你如果你唔識既話就唔得勒。

Q: 咁譬如你覺得唔識英文，咁可唔可以再請你解釋少少你話如果唔識英文咁個後果會係點樣？

A: 如果唔識英文，拿，譬如如果你醫院內部開會，咁可能 D 醫生都全部，即係一個比較正式既會議，佢可能用晒英文喎。如果當你，即物理治療部個主管，或者係佢代表去開會，而佢個英文表達係唔得既，甩甩咳咳既，咁我諗人地就會有一種異樣既眼光，即係覺得你「嘩！你得唔得架！」咁樣。

Q: 即係甚至乎會……

A: 係勒！會對個形象有 D 形響。

Q: 即係會唔會影響到對佢係工作能力個方面個形象都會有影響呢？

A 如果對佢唔係好熟既話呢就我諗唔多唔少都會有 D。但係如果係相熟既話就知道佢個人做唔做倒野，人地就唔會用你既語言去衡量。

Q: 咁你會覺得英文都可能俾倒一 D 初步既印象會好 D 丫如果你英文流利既話？

A: 唔。

Q: 咁你覺得廣東話同國語之間，咁會唔會亦都有同樣出現呢？可能會俾你一個好 D 既形象呢？

A: 我諗其實呢冇邊個優惠既，即係如果你三樣野都識，咁三樣野都好啦。但係我就覺得你廣東話係一個方言黎既，咁可能就國語如果一定要比就國語就比較優先一 D。

Q: 國語係比較優先一 D？

A: 係。

Q: 咁另外就想睇下根據番份問卷，其實點解你話講到一 D 臨床經驗同埋一 D 專業知識冇令你覺得一個 expert，作爲一個物理治療師？即係其實點解你認爲冇咩大影響呢？

A: 因爲如果你真係 expert 呢，我覺得你既意思專家啦！

Q: 係。

A 我覺得專家你要真係擺好多時間專門去研究某一樣野，或者專門做某一樣野，然之後你累積左既經驗，而好多人都唔識既，唔及得你既，咁個陣時你先至可以叫你自己做專家。

Q: 係。咁另外有一條我都好有興趣知就係話，你唔認爲呢病人需要遵從你既 instruction，遵從你既指示，點解會因爲你作爲專業人士，點解你會有一個咁特別既睇法呢？

A: 我諗以前你係有呢個咁既概念既，就係「我講既野你一定要聽，你一定要做」，但係依家就唔同勒，依家呢個世界個個人都係度講人權，講病人有病人權益，咁所以呢如果我叫佢做某一 D 野，咁佢認爲佢唔可以接受既，佢可以拒絕。咁正如如果病人係醫院，醫生叫佢接受某一種治療，咁佢拒絕既話呢，咁都唔可以話強迫個病人去接受既。咁所以我覺得呢野係因爲人權既問題，同埋病人權益既問題。

Q: 係。其實講起病人權益，其實你覺得 patient-centered approach，其實你點樣睇架對於呢一樣野？

A: 其實我覺得有好有唔好呢一樣野，因爲你自己身爲一個專業人士，你係用你既專業知識，咁應該黎講個病人係聽你既。但係當你轉左一個 patient-centered 既模式呢，咁變左我地就係一個服務行業，如果你係服務行業既話呢，咁幾時都係你既客仔至上架勒，咁其他野都可以擺埋一邊。咁所以我覺得有好冇唔好啦，即係適當地我地要尊重病人個權力啦，佢既選手啦。但另一方面呢，其實病人都係要相對地知道佢都有呢個責任去聽我地講，或者尊重我地個吩咐。

Q: 係。咁我諗今日訪問差唔多，唔該晒！

Transcript 4

Q: 一九九八年二月十一日，訪問四，咁係我地開始之前呢，首先多謝你呢參與我地呢個訪問。我想作多少少補充就係話呢呢個訪問大概會係一個鐘頭左右，我就係話希望藉此加深了解下作爲一個專業人士，即係點樣睇香港個語言運用啦，同埋一 D 有關既睇法。咁呢個訪問就會係錄音，同埋將來會作爲研究用途。咁如果係呢個訪問期間有 D 咩野問題你覺得尷尬或者係引起你不安，你可以隨時拒絕回答呢個問題啦，甚至乎就係終止訪問。同時，係做完整個研究之後，
我地會將呢盒帶燒毀既。我地保證呢 D 資料係會絕對保密啦，同埋你係會以不記名既形式接受訪問既。你有無咩問題呢？

A: 冇呀。

Q: 咁如果係咁，我地開始 interview 啦。我想問呢，由一分至十分入面呢，一分爲之最低，最差既，十分爲之最好既，你覺得自己個中文既語言能力，你會俾幾多分呢？

A: 即係純粹講廣東話？

Q: 係。

A: 講野表達既。

Q: 我意思總括黎講，你如果俾自己中文既程度黎講，你會俾自己幾多分呢？

A: 七至八分啦！七至八分。

Q: 咁如果係英文呢？你覺得自己英文程度你會俾幾多分呢？

A: 六至七分啦！

Q: 咁如果深入 D 去睇啦，譬如你覺得係書寫方面，中文你會俾自己幾多分呀？

A: 七分倒啦！

Q: 咁如果書寫英文呢？

A: 差唔多啦。

Q: 都係七分。咁譬如係語言方面，咁廣東話你會俾自己幾多分？

A: 廣東話八分倒啦！

Q: 咁英文，譬如自己俾講個方面自己有幾多分呀？

A: 六至七分。

Q: 咁普通話呢？

A: 五分啦！

Q: 咁其實你係日常生活之中，你通常會揀邊種語言作爲溝通工具？

A: 日常既生活，中文啦，有時會夾 D 英文。

Q: 你中文既意思係……

A: 廣東話。

Q: 廣東話夾 D 英文，其實點解會用呢種語言俾較多 D 呢？

A: 廣東話就大家都明啦，但可能有時讀書或者係玩可以呢，有 D common 既野，大家都明，可以用英文黎表達。

Q: 咁有冇 D 情況你會係講廣東話既呢，純粹係廣東話既呢？

A: 係屋企囉。

Q: 點解呢？點解會用廣東話呢？

A: 因爲屋企人唔識英文囉。

Q: 咁如因係純粹講英文呢？

A: 如果返工個陣時候，可能遇到一 D 唔識廣東話既病人。

Q: 有冇純粹講普通話呢？

A: 都係一樣，撞到既人唔識其他語言，佢剩係識普通話既。

Q: 咁即係其實你係好視乎個對象，即係如果佢識講邊種語言，你就同佢揀番，即係用番佢識個種語言？

A: 係。

Q: 咁頭先提到你同屋企人會用廣東話比較多 D，咁同你既兄弟姊妹呢，你就係問卷入面你揀廣東話同埋英文。其實點解有呢個分別架呢？

A: 有時有 D 野唔想俾爹 D 媽咪知，咁可能會用英文。同埋有時可能講野慣左啦，鍾意兩樣野溝埋一齊，覺得會表達得容易 D 囉。

Q: 即係覺得會表達得，咁同同事呢，你係問卷入面揀左廣東話同英文夾雜啦，咁其實又有冇咩野特別原因呢？

A: 都係一樣即係同頭先既原因一樣。

Q: 即係話容易 D 明白，同埋就……即係有冇 D 野唔想俾病人知，即係頭先你提出兩個，一個係屋企同兄弟姊妹就唔想……

A: 都會既。

Q: 其實可唔可以再詳細 D 講下如果唔想俾病人知，點解有咁樣既情況呢？

A: 譬如有陣時講病人既 condition 呢，或者係一 D 好 subjective 覺得病人既 feeling 啦，咁又唔想俾佢知道，咁就用英文講。

Q: 即係你指既意思係對住其他同事既時候，既我想再深入 D 瞭解，既係譬如個病人佢又識廣東話既，又識英文既，即係佢教育程度某程度上佢都幾高，咁係呢個情形之下你會點樣做呢，譬如有 D 野又唔係好想俾佢知咁樣？

A: 咁唔會係佢面前講。

Q: 咁其實你覺得香港依家大部份既病人懂廣東話都佔幾大部份，咁覺得識廣東話同英文既依家既況點樣呢？

A: 你指情況既意思係？

Q: 即係病人佢普唔普遍普呢識廣東話同英文兩者之間？

A: 都係一半一半，既視乎佢既年紀係去到邊度。通常我地接觸既病人就係後生 D 個 group 會兩樣都識，上左年紀個 D 可能就剩係識廣東話。

Q: 咁呀譬如同波士或者係上你都係揀廣東話同英文，有冇咩特別既原因？

A: 因爲可能時有 D technical 既 terms，咁我地根左唔知。或者覺得用英文容易 D 表達，咁會夾雜 D 英文落去。

Q: 咁同朋友，即係係訪問初頭，你都有提到用廣東話同英文，因爲容易 D 溝通，咁呀如果同病人主要都係廣東話，除左你頭先提過因爲佢剩係識廣東話，有冇其他原因你會用廣東話呢？

A: 佢會容易 D 明，同埋會親切 D 囉，佢會覺得，因爲大家都係中國人，咁你用番大家容易 D 溝通既語言會好 D。

Q: 咁其實你覺得係語言選擇同對象，你覺得兩者之間有冇關係，又或者係如果有關係，個關係會係點？

A: 都會有關係。

Q: 個關係會係點？

A: 你指邊一樣，我唔係好明。

Q: 即係譬如你揀香港最通常用緊廣東話、英文同普通話啦，你揀邊一種語言黎講，同你對個人物個方面，即係我同呢個人講，同個個人講，會有所唔同既呢？

A: 會既，可能會視乎睇下佢既背景係點樣，譬如同長輩，如果你兩樣野溝埋黎講，可能會覺得你冇禮貌，或者讀番書，走去學人講英人，即係會用番佢地喜歡講既語言同佢地溝通啦。譬如同自己既朋友既話呢，大家同埋個 age group，接觸既野又差唔多，好多時兩樣野溝埋黎講，咁譬如你同病人，因爲你保持你番你自己既專業呢，好多時你會用番中文，唔想兩樣野溝埋。咁就好似變左唔得專業，或者你就就用晒英文，用晒中文，好少兩樣野溝埋黎講。

Q: 其實呢我就好有興趣想繼續知點解會覺得用純中文或者純英文係比較上專業一 D 呢？即係其實係好有興趣知道點解會俾到一種咁樣既感覺。

A: 點解呀。可能你會...因爲頭先講過啦，因爲中國人既關係，咁你係表達你自己既時候，你應該係可以用番你自己既語言黎表達，咁你就算係一 D technical terms，你都可以解釋得好清楚，同埋好多時病人未必一定既係知道一 D technical terms，就算你講左英文出黎，個 terms 出黎佢可能都唔知道係咩野，咁你用你自己最容易溝通既語言講番出黎都可以解釋得到，咁所以比較起上黎會覺得係專業少少囉。

Q: 咁另外勒，譬如你用邊一種語言，廣東話又好，英文或者夾雜肆但兩樣一齊咁講同係邊個場合會唔會有關係呢？即係係唔同場合自然會講 D 唔同語言，會唔會有咁既情形？

A: 都好似頭先咁講，要視乎個對象係 D 咩野人。

Q: 咁譬如會唔會話同朋友，我同佢係街度講野，或者返工既時候，會變左係語言上既選擇會有所唔同呀？即係我想知道同一個人會唔會係唔同既地點你會用唔同既語言呢？

A: 可能係用詞個度會有唔同。但係係選擇語言個方面，即係譬如中文或者英文會有好大分別。

Q: 咁係個提材呢，會唔會譬如有時唔同既提材會用唔同語言呢？

A: 都可能會既。譬如講 D 公事，咁就一定兩樣野溝埋，譬如講一 D 去玩，睇戲既，都會少 D，少 D 溝埋兩樣野，都會有機會既。

Q: 咁其實你覺得人物、地點同提材有冇具體 D 既關係呢，幾方面如果夾雜一齊。即係你頭先都分左同唔同既人啦，唔同既地點啦，唔同既地點可能比較少 D，唔同既提材用唔同既語言啦，請你再概括講下幾樣野夾埋一齊，佢地既關係會係點呢？

A: 我諗其實你用邊種既語言，最主要視乎你既對象係咩野。你既對象係咩野，就會影響你既話題係咩野，咁先會影響你用 D 咩語言囉。咁所以我覺得最重要個人物係咩野。

Q: 即係人物、地點同埋題材，你覺得人物影響最大，既係三者之中。咁呀你對於依家香港現存語言既制度，即係譬如香港比較特別 D 既城市，對於咁英文、廣東話同普通話，都會係一個可以用到既語言，既你對於依家咁既情形你有 D 咩睇法呢？

A: 你指...

Q: 即係香港咁樣兩種語言，一種方言夾埋一齊咁用你覺得係好呀，定會有 D 咩影響呢？

A: 我諗剩係譬如 confined to 香港一個咁細既城市，咁譬如對外黎講，剩係識廣東話或者係普通話兩樣野，其實對外既溝通會係唔夠既。好多時出到去外面，大家最 common language 就係講英文，如果你剩係識得廣東話或者普通話，對外既溝通會有影響囉。依家好似教育制度黎講佢話全部都話選擇母語教學，咁可能呢一個階段 D 學生會覺得母語教學會吸收多 D，識既野會多 D，咁但係可能會發覺以後對外既時候，佢表達唔到自己。因爲你出到去大家既 common language 係英文，因爲你學得唔好，變左你影響到將來既發展。

Q: 即係其實你覺得如果香港既教育制改變，你會擔心將來國際地位上出現問題。譬如 health care system 因爲三種語言既存在有冇咩影響呢，或者兩種語言一種方言一齊共用？

A: 你指係讀書既時候三種語言共用丫，定係指出黎做野既時候，係呢個 field？

Q: 或者我地可以分兩個層次，講下讀書個陣時，因爲我地大部份響 Poly 畢業，個陣時讀英文啦。但係出到去可能用廣東話，甚至乎可能講國語呀。你覺得教育制度有冇一 D 咩意見呢？

A: 如果我睇番我自己，或者一 D Poly 入面 student 啦，佢地學既時候係用英文，佢地初初出黎對住病人既表達能力係比較低 D 既，好多時佢會將學既野將英文突然譯番過黎中文，咁就表達唔到自己。所以佢用晒英文黎教既時候，可能對於第日出黎做野既表達能力比較困難。但係如果用晒中文既時候，即係我頭先咁講，對

外既時候變左有 limitation，如果好 D 既，兩樣野，中文同英文夾雜埋一齊會比較好 D。

Q: 譬如再講後者，到出黎做野，你覺得係溝通上方面有冇問題呢？因爲好多時寫 report，寫英文既，但同病人，同其他同事可能講唔同既語言，你覺得有冇困難呢？

A: 我覺得要視乎個別既人黎睇。有 D 人適應能力比較強 D 既，可能係好短既時間完全適應到用中文黎表達番自己，雖然你學既野係全部英文，你可以好容易用番中文黎表達自己，咁譬如普通話就比較少用 D 囉係我地黎講，咁所以我地黎覺得講普通話係比較困難 D，如果真係要我地用普通話黎表達自己

Q: 譬如如果我地將母語改左爲普通話既時候呢？即係經常性用普通話，你有 D 咩睇法呢？

A: 有 D 野可能表達唔到出黎，因爲廣東話好多字，好多 terms 好得意既。普通話講唔到出黎，唔係好傳神囉。

Q: 你覺得作爲一個專業人士，作爲物理治療師，同病人溝通呢係做治療時，你覺得重唔重要？

A 重要既。

Q: 點解呢？

A: 因爲個病人一定要知道你係度做緊 D 咩野野。你要講俾佢聽你依家究竟係做緊 D 咩，同埋點樣可以幫到佢。

Q: 你覺得同病人之間既溝通，會唔會有 D 咩困難既地方？

A: 有既。

Q: 邊一方面？

A: 好似頭先咁講，三種語言好似比較普遍 D，但係其實有 D 係譬如好似客家，上海個 D 既時候會覺得講唔到，同埋有陣時有病人真係唔會好明白，就算你用廣東話講，佢都唔係好明白你想做 D 咩野野。咁變左個一撮病人黎講個溝通上面會有 D 問題。

Q: 譬如如果咁既情況你會點樣去解決，或者改善之間溝通呢？

A: 一係就睇下有冇屋企人係到幫佢翻譯，如果唔係就要用埋 body language 做一次比俾佢睇。

Q: 你頭先都提到少少啦，學既時候用英文啦，講番出黎既時候用廣東話，或者甚至乎中文既名詞，你覺得有冇困難，係你每日返工既時候要做一 D 解釋，或者示範既時候用黎轉換語言，有冇困難既地方？

A: 依家可能做得大耐野，覺得有咩大問題，好多野可以好自然咁講，除非你話一 D 好 special 既 terms。譬如你我講 tibia 既中文，fibula 既中文呀個 D 就會好難囉，咁但普通解釋你要做 D 咩野，治療上面既野都覺得 OK，冇大問題。

Q: 你覺得你經驗令到你覺得容易左。咁其實有冇一 D 途徑去學，或者促進到去學中文詞彙既時候呢比較有效 D 或者容易 D 咁樣呢？

A: 咁其實好多時以前就係聽 D 師兄師姐呀。佢點樣同 D 病人講野呀，咁係佢地個度學番黎。

Q: 譬如你自己作爲一個物理治療師，你覺得最好最適合既語言同病人溝通係邊一種語言呀？

A: 即係如果俾我選擇？

Q: 係。即係你覺得係最好最理想既。

A: 最理想呀，可能用兩樣夾埋應該係會好 D 既，即係中文同埋英文。

Q: 中文既意思係？

A: 廣東話。

Q: 即係廣東話同英文，點解呢？

A 即係好似頭先咁講，廣東話好多字可以俾較傳神一 D，但係英文有 D term 成日都會學，學校既時候會用呀。譬如好似 traction，咁你話俾人聽拉腰，雖然都叫做傳神，佢都明既，但係其實就唔係 traction 個樣野囉。

Q: 咁另外同同事呢，你覺得最好既語言係用邊一種呢？

A: 最好既語言...

Q: 即係你會覺得最好既選擇係邊一種呢？

A: 都係一樣。

Q: 咁譬如你覺得寫個報告呢，你覺得邊一種語言係最好呀？

A: 英文囉。

Q: 點解呢？

A: 可能一路學既都係用英文多啦，咁會覺得比較容易 D 表達自己。同埋英文容易 D 寫啦，中文會寫得好辛苦，好困難。

Q: 其實你贊唔贊成，因爲現存既制度用英文教學，你贊唔贊成作出一個改變呢？

A: 你指教育制度，我唔贊成。

Q: 因爲你頭先提過因爲驚個競爭，個國際對外個方面...

A: 因爲其實我覺得譬如廣東話，或者中文呢個係你與生俱來既能力，變左你唔需要特別話去學既語言。反而英文呢你係一樣完全唔識係野，咁你變左你學左呢一樣野，好似拎住一條鎖匙出去出面。

Q: 咁其實我想拉開少少啦，問關於物理治療師佢個專業地位咁。譬如你覺得香港物理治療師個決策權係點樣呢？

A: 其實都唔係話咁大既，好視乎每一 D 個地方而唔同既。基本上個決策權都唔係好，好多時都會係個醫生個度，咁譬如我地係醫院做野，好多時佢會話係你聽，佢會 order 你呢個只可以俾 non-weight，partial weight。呢一樣野就一定要跟佢地啦。但係如果你係一個 out-patient setting 個度，咁譬如佢腰骨痛，咁變左話就咁 back physio，或者甚至乎寫要 shortwave 啦，但係你檢查個病人覺得冇咁既需要，你都可以改，但係最後決策權仍然係個醫生

度，因爲佢可以決定個病人重需唔需要繼續黎做物理治療師，好多時你覺得唔需要，但係可能個醫生覺得需要，咁你仍然都要睇住呢個病人，變左好多野你自己都決定唔到。

Q: 咁俾你個感覺上，其實你點樣睇佢個專業權威？

A: 你指普遍既人？

Q: 係。即係譬如病人呀、一般大眾市民，佢地會點樣睇香港既物理治療師。

A: 可能佢地會覺得，佢地會係，物理治療師會係醫生之下既。咁但係就會俾其他既 professional 就會高少少，咁但係始終唔會夠醫生個咁權威，即係雖然好多野 D 病人，D 物理治療師會係幫到佢地最終譬如佢行得到，都係因爲物理治療師幫到佢，咁但係佢會覺得最大既，即係最幫到佢地個人係醫生囉。

Q: 咁其實你覺得某一種語言會令到物理治療師係權力上，會唔會有 D 改變呀，即係會唔會講某一種語言，佢好似叻 D，威 D 呀？

A: 我覺得唔會架。可能呢個階級既概念呢已經好根深蒂固，所以我覺得如果就算講邊一種語言都唔會太大既改變，因爲好多時巡房既時候 D 病人都見到我地有時會同醫生用英文溝通，雖然醫生都係用英文黎溝通，咁但係對於個病人黎講，佢仍然覺得醫生係最高級既，跟住之下先輪到我地呀。

Q: 咁其實你覺得係關於個職業上既問題，而唔係講邊種語言既問題？

A: 可以咁講。

Q: 咁重有幾條問題想再了解一下社會點樣睇我地既 social power。咁其實點解你會覺得作爲一個物理治療師，決定揀邊種治療既方法既時候呢，你係站中立既態度呢，即係你又唔認爲可以全權性可以幫佢決定，亦都唔認爲唔可以幫佢決定，咁其實點會有咁既睇法呢？

A: 其實我係可以幫佢決定既，但係最終佢接唔接受係佢個度，因爲依家病人約章佢有權利選擇做定唔做，但係我可以話俾佢聽我會俾呢一樣治療你，咁其實最終既決策權係佢度。

Q: 咁譬如你覺得病人都需要遵從你既指示或者忠告，其實你點解可以有咁既睇法呢？

A: 因爲我覺得我會比較了解佢既情況，咁佢其實我有我既專業特長可以話俾佢聽，佢有 D 咩問題，點解佢要聽我講，咁所以我覺得佢應該要聽。

Q: 咁其實你覺得會唔會稱自己爲一個 expert，一個專家，係物理治療方面？

A: 因爲物理治療 cover 既野好大，咁如果話自己係一個專家其實仲有好多野要學，譬如我覺得學極都學唔哂 D 野，咁所以如果你話一個好細既 area 你要 further develop 既話先可以叫自己做一個專家，但其實都離專家重係好遠。

Q: 但係會唔會覺得自己俾病人覺得係一個專家人士呢？

A: 咁都會既。

Q: 咁譬如遇到一 D 情形就話當你唔係妳同意病人既一 D 睇法，或者係一 D 做法，我當然係指治療個方面個問題，咁你就話你都可能會嘗試去改變病人個睇法，或者係一 D 係意見。咁我可唔可以請你再詳細解釋一下？

A: 因爲個陣時，好多時 D 病人佢自己可能有一個概念就係話我依家係咁樣樣，一定要咁樣樣先至可以幫到我。咁但係其實我幫佢檢查完發現都唔係既，佢可能要 B 個方法先至可以幫到佢，先至係最好係，咁我嘗試去改變佢個觀念。

Q: 咁你覺得有冇因難呀嘗試咁做既時候？

A: 基本上其實依家既病人呢佢都會覺得我地真係幫緊佢，就唔係話特登針對佢既，因爲有時有 D 人咁樣諗。即係有少部份係會咁樣諗，所以其實要改變佢地既諗法都唔係困難，最緊要我覺得係你解釋到俾佢聽點解囉！

Q: 咁好啦，咁今日呢一個訪問差唔多勒，唔該晒！

Appendix V

Letter from the Hong Kong Physiotherapy Association

HONG KONG PHYSIOTHERAPY ASSOCIATION
香 港 物 理 治 療 學 會

28 July 1997

Ms Cheung Pui Yee, Polly
MPhil Student
Department of Health Sciences
The Hong Kong Polytechnic University
Hung Hom
Kowloon

Dear Ms Cheung,

Application for the membership list of
the Hong Kong Physiotherapy Association

Your letter dated 15 July 1997 refers.

I am sorry to inform you that due to the enactment of the Personal Data Privacy Ordinance and our code of practice, I am not able to offer you our membership list as requested.

Being a professional association, we are happy to support research work. One possible option is that we can distribute your request or questionnaire to our member for you at cost. However, this will be subjected to the approval from the Executive Committee after reviewing your project.

Thank you for your letter. Please let me know anything I can help.

Yours sincerely,

(Jimmy Wu)
President, HKPA

P. O. BOX 10139, GENERAL POST OFFICE, HONG KONG.