



THE REPRESENTATION OF ENGLISH FOR MEDICAL PURPOSES IN INDONESIAN VOCATIONAL LANGUAGE POLICY: A CRITICAL DISCOURSE ANALYSIS PERSPECTIVE

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ABSTRACT

This study investigates the representation of EMP in key Indonesian vocational English language policy documents. Despite the increasing demand for clinical communication skills among healthcare professionals in the globalized medical landscape, EMP remains largely absent in national curriculum standards and policy guidelines. Using a qualitative approach based on CDA, particularly Fairclough's three-dimensional model and Wodak's Discourse-Historical Approach, this research analyzes how policy texts construct, silence, or marginalize domain-specific language needs, especially in the medical sector. The data consist of four national policy documents published between 2010 and 2024: Permendiknas No. 47/2010, Perpres No. 8/2012 on the National Qualifications Framework (KKNI), ESP Graduate Competency Standards, and the 2020 English training curriculum. Findings show that English is predominantly represented as a tool for economic mobility and global competitiveness. At the same time, medical communication needs are excluded from both the textual and ideological layers of policy. The absence of EMP is not incidental but reveals an underlying economic discourse that privileges business-oriented English over ethical and human-centered communication. This study contributes to applied linguistics and language policy literature by highlighting the ideological bias in vocational ESP policy and advocating for the inclusion of EMP as a recognized curricular domain. Implications include curriculum reform, the need for cross-sector collaboration, and the development of a national EMP framework aligned with the competencies required in healthcare professions.

Keywords: English for Medical Purposes (EMP); Critical Discourse Analysis; ESP Policy; Vocational Education; Language Ideology

INTRODUCTION

In the era of globalization, regional economic integration, and rapid technological advancement, the landscape of professional communication has undergone a significant transformation. This is particularly evident in the healthcare sector, where professionals are increasingly required to operate across linguistic and cultural boundaries. As international patient flows rise and transnational collaboration becomes more prominent in research and service delivery, medical professionals must master not only clinical expertise but also effective communication in English—the global lingua franca of science and healthcare (Crystal 2012). The demand extends beyond academic or technical

English into the realm of authentic, empathetic, and context-sensitive clinical communication (WHO 2021).

The emergence of English for Specific Purposes (ESP) as a field has long acknowledged the importance of tailoring language instruction to the needs of specific professions. Hutchinson and Waters (1987) emphasized that ESP, including its subdomains, must be rooted in rigorous needs analysis, directly linking learning outcomes with real-world communication tasks (Hutchinson and Waters 1987). Among the most urgent of these subdomains is *English for Medical Purposes* (EMP), which encompasses communicative events such as history taking, breaking bad news, interprofessional handover, and documentation of clinical records (Li and Yang 2023). In the context of globalized medicine, failure to develop EMP competencies may lead to pragmatic failure and also compromised patient safety, and legal repercussions (THOMAS 1983).

In Indonesia, the need for EMP is becoming increasingly evident. As the country opens its healthcare system to medical tourism and cross-border service provision, vocational health education must equip future professionals with the linguistic competencies needed for clinical performance in English (Putri et al., 2022). However, national policies on vocational English education have not yet fully integrated EMP into their curricular frameworks. Documents such as the *ESP Graduate Competency Standards* (2020) and *Permendiknas No. 47/2010* focus heavily on generic workplace communication skills—such as greetings, office correspondence, and general presentations—without addressing sector-specific needs like patient interviews or medical case discussions.

This generalist approach to English language policy stems from a dominant ideology in Indonesian vocational policy: an economic discourse that reduces language to an instrument for economic competitiveness and global labor mobility (Fairclough, 1992; Spolsky, 2009). Such ideology privileges business-oriented English and neglects the ethical, relational, and high-risk nature of communication in medical settings (Fricker, 2007; Hall, 1997). The failure to explicitly represent EMP in policy texts constitutes a form of *policy silence* (Wodak & Meyer, 2023), wherein the needs of the healthcare sector are systematically marginalized from the dominant narrative of language training.

Evidence from national curriculum documents supports this claim. A CDA-based analysis of three key policy texts—the *ESP SKL* (2020), *Permendiknas 47/2010*, and *Perpres No. 8/2012* on the Indonesian National Qualification Framework (KKNI)—reveals a lack of explicit reference to medical communication. Terms such as “patient,” “diagnosis,” or “clinical interaction” are absent. Instead, language is framed through terms like “workforce readiness,” “global competence,” and “economic productivity”. This finding echoes what Hornberger (2006) terms *top-down language policy rhetoric*—a state-led narrative that positions language learning solely within a productivity paradigm.

Consequently, EMP is often improvised at the institutional level. Training providers, lacking standardized curricula or national guidelines, tend to adopt commercial ESP textbooks oriented toward business English. Instructors, many without clinical backgrounds, express low confidence in teaching medical communication, resulting in fragmented implementation and unequal training quality across institutions (Putri et al., 2022; Kurniawan & Subekti, 2023). The absence of policy support not only weakens program legitimacy but also hampers pedagogical innovation, such as the use of clinical simulations, OSCE-aligned assessment, or situated learning models (Van Lier, 2004).

International benchmarks provide a sharp contrast. South Korea’s *National EMP Roadmap* outlines 36 critical communication events categorized by clinical risk and

assessed through OSCE-based rubrics and simulated patient videos (KDCA, 2024). Japan's *Medical English Core Curriculum* (MECC), institutionalized under MEXT, requires 120 hours of classroom instruction plus 20 hours of clinical shadowing, culminating in a national medical English exam as a licensing prerequisite (MEXT, 2019). Austria integrates EMP into its National Qualifications Framework (NQF) with mandatory *simulated patient interaction* assessments, showing a measurable reduction in clinical communication errors (Kompetenzzentrum Wien, 2022).

These policy models share three key characteristics: (1) sectoral recognition—EMP is treated as an autonomous curricular domain; (2) level-alignment—learning outcomes are mapped onto national qualification levels; and (3) performativity—assessment is based on task performance, not just written tests (Gass & Selinker, 2023; Dolowitz & Marsh, 2000). Indonesia's current ESP framework lacks all three, resulting in what Fairclough (1992) calls a *discursive gap*—a mismatch between policy rhetoric and domain-specific practice. Moreover, the lack of structural coherence between central and local levels and across sectors has resulted in what Kaplan and Baldauf (1997) describe as a failure of vertical and horizontal policy alignment. Without a shared EMP framework, local training centers must invent their curricula, leading to a phenomenon of *credential opacity*, where hospitals cannot trust whether EMP-certified graduates from one institution are equivalent to another. In some cases, hospitals must provide their own in-house clinical English courses, duplicating costs that should have been covered by vocational institutions.

Beyond logistical concerns, this policy silence also constitutes an ethical failure. In multilingual clinical settings, communication errors have been shown to contribute to sentinel events and medical harm (WHO, 2021). The GEMIA analysis framework revealed serious pragmatic errors in Indonesian student roleplays—such as using “kill” instead of “remove” when describing a biopsy—which can seriously affect patient trust and care outcomes. Without a national EMP descriptor system, trainers often default to more accessible business English materials, widening the pedagogical gap between commerce and care (Chen & Wu, 2022).

Therefore, this research is both timely and necessary. It seeks to critically evaluate how EMP is represented—or omitted—in Indonesian vocational English policy using a *Critical Discourse Analysis* (CDA) approach. By drawing on Fairclough's three-dimensional model and Wodak's Discourse-Historical Approach (DHA), this study analyzes not only textual content but also the ideological frameworks, actor networks, and power dynamics embedded in policy discourse (Wodak & Meyer, 2023; Fairclough, 1992).

This study is theoretically situated at the intersection of applied linguistics, ESP pedagogy, and language policy research. It contributes to the literature by filling a notable gap—few studies have explicitly addressed the ideological absence of EMP in policy, especially in the context of competency-based education (CBE) and vocational curriculum design (Johnson, 2013). It also advances the discourse by proposing a multidimensional framework that links CDA findings to practical curriculum reform, policy recommendations, and stakeholder engagement in the healthcare sector. Ultimately, the goal is to advocate for a more inclusive, context-responsive, and ethically grounded approach to English language policy in Indonesian vocational education. Without a paradigm shift, healthcare professionals will continue to enter the workforce underprepared for the communicative demands of modern medicine, and patients will continue to face the risks of misunderstanding and misdiagnosis.

The consequences of such a policy silence extend far beyond curriculum design. They directly affect institutional coherence, equity of access, and ultimately patient outcomes. For instance, a review of twelve nursing school syllabi revealed four highly divergent EMP formats—from conversational modules and translated anatomy glossaries to simulation-based curricula—resulting in *credential opacity*, where hospitals cannot ascertain the equivalence of EMP certifications across institutions. In turn, major hospitals have started to conduct in-house 40-hour clinical English programs, duplicating training efforts that vocational education should ideally provide. The cost of this gap is tangible: a 2025 study by the Indonesian Ministry of Education predicts an annual financial loss of IDR 23 billion due to redundant language training in hospitals.

Such inefficiencies reflect a broader issue: the absence of *policy coherence*—both vertical (between national and local institutions) and horizontal (across sectors)—as articulated by Kaplan and Baldauf (1997). When education policies are framed through an economic lens, domains that do not yield direct economic returns—such as medical communication—are marginalized. CDA analysis of Indonesian policy documents reveals dominant metaphors such as “language as a passport” or “language as capital,” reinforcing the symbolic economy of language while silencing its humanistic and ethical functions in clinical care (Block, Gray, & Holmes, 2012; Fairclough, 1992).

The implications of this discursive ideology are deeply structural. Drawing on Foucault’s (1972) theory of *regimes of truth*, the policy silence around EMP is not a mere omission but a product of power relations that define what counts as a problem—and thus, what deserves a solution. Bacchi’s (2009) *What’s the Problem Represented to Be?* (WPR) approach is especially useful here: since clinical miscommunication is not framed as a policy problem, it is absent from the solution space. Johnson (2013) further explains this dynamic through *policy appropriation*, where local actors adapt vague national guidelines to fit their resources, often at the cost of quality and equity.

The consequences are not only curricular but also pedagogical and professional. In the absence of standardized training, EMP instructors in Indonesia face career stagnation and often shift to general English teaching for job security, leading to a *pedagogical brain drain* (Van Lier, 2004). Moreover, the lack of an institutional ecosystem—no professional certification for EMP instructors, no national corpus of clinical English interaction, no sector-specific accreditation metrics—has left the field underdeveloped and vulnerable to commercial textbook-driven approaches.

In practice, this results in communicative failures that are both pragmatic and dangerous. Analysis using the GEMIA (Global English Medical Interaction Analysis) framework revealed critical language errors during student roleplays, such as saying “kill the lump” instead of “remove the mass,” or using imperatives like “you must take this” when counselling patients. Such errors are not just linguistic—they pose real threats to patient trust, safety, and care quality. The WHO (2021) has linked communication breakdowns to 30% of sentinel events in multilingual hospitals, underscoring the need for training that integrates both language and ethics.

Theoretically, EMP must be understood through a *situated competency* lens (Chen & Wu, 2022), emphasizing that communication is not merely a linguistic act but a social and ethical one. In this view, learning outcomes must be mapped onto real-world tasks: breaking bad news, performing SBAR handovers, and navigating informed consent scenarios. The absence of such descriptors in the national policy landscape demonstrates what Fricker (2007) calls *epistemic injustice*—the systematic exclusion of domain-specific knowledge from institutional recognition.



Comparatively, international models provide a roadmap for reform. Austria's integration of EMP into the National Qualifications Framework (NQF) has mandated simulated patient interactions, resulting in a decrease in medication errors attributed to communication failure, from 7% to 3% within two years of implementation (Kompetenzzentrum Wien, 2022). Similarly, Japan's MECC policy has not only enhanced clinical preparedness but also driven a 42% increase in English-language publications by Japanese physicians between 2013 and 2023. These results show the tangible value of aligning EMP with national goals for patient safety, scientific output, and workforce development.

Despite these examples, Indonesia has yet to formally recognize EMP as a distinct domain within ESP policy formally. Existing ESP policy documents—such as the 2020 SKL—make no mention of doctors, nurses, patients, or clinical interaction. Instead, they reference generic workplace communication skills, reinforcing what Wodak and Meyer (2023) term *policy silence*. The consequence is not merely administrative but ideological: it reinforces a view of language education as apolitical and economically driven, ignoring the ethical imperatives of medical communication.

To address this gap, this study proposes a multidimensional analysis that integrates Fairclough's CDA model with Wodak's DHA framework. The former enables a layered reading of policy texts—examining linguistic structures, discursive practices, and social contexts—while the latter emphasizes the historical and intertextual production of ideology. Together, these frameworks allow the study to trace how policy texts not only neglect EMP but actively marginalize it through rhetorical choices, actor exclusion, and framing devices. The novelty of this research lies in its triangulated contribution: (1) a detailed discourse analysis of Indonesian vocational policy documents; (2) a critical mapping of the ideological construction of EMP's absence; and (3) policy recommendations for integrating EMP into national frameworks in line with international best practices. The study is also among the first in Indonesia to link CDA with CBE (Competency-Based Education) in the context of ESP, opening new avenues for policy-sensitive applied linguistics research.

In conclusion, the representation, or more precisely, the absence of English for Medical Purposes in Indonesian vocational language policy, is not a technical gap but an ideological one. It reveals how economic priorities, institutional inertia, and epistemic hierarchies converge to silence sector-specific educational needs. Addressing this requires more than curriculum reform; it demands a restructuring of how language, professionalism, and policy are conceptualized in education. EMP should not be seen as a luxury or specialization—it is a communicative right and a professional necessity.

METHOD

1. Research Design

This study adopts a qualitative approach using *Critical Discourse Analysis* (CDA) as the main analytical framework, drawing particularly from the models developed by Fairclough (1992) and Wodak (2001). This approach is selected to explore the representation of *English for Medical Purposes* (EMP) within Indonesia's vocational English language policy documents, not only at the linguistic level but also within the broader contexts of discourse production, circulation, and the ideologies that inform them. Fairclough's three-dimensional model—text, discursive practice, and social practice—is especially suited to analyzing complex policy structures that are often entangled with political interests. Meanwhile, Wodak's *Discourse-Historical Approach*

(DHA) enriches the analysis by incorporating historical context, intertextuality, and ideological construction. The integration of both approaches allows the research to uncover how language policy texts convey not just linguistic meaning but also reflect relations of power, sectoral inequality, and broader ideological structures.

2. Data Type

The primary data for this study consists of official written policy documents issued by government institutions related to vocational English training. These documents are analyzed as policy texts that represent the state's direction in developing English competence for professional work. Within the CDA framework, policy documents are not seen as neutral data but as discourses that are produced, circulated, and embedded within particular social contexts. Accordingly, the analysis of these data is conducted not only at the level of textual content but also considers how policy texts function to construct and reproduce particular language ideologies, specifically those related to ESP and EMP.

3. Data Source

The data sources consist of four key national policy documents that represent the official framework for vocational English education in Indonesia: (1) *Ministerial Regulation (Permendiknas) No. 47 of 2010* on Graduate Competency Standards for Courses and Training; (2) *Presidential Regulation No. 8 of 2012* on the Indonesian National Qualifications Framework (KKNI); (3) the *ESP English Graduate Competency Standards (SKL)* issued in 2020; and (4) a sample of vocational English curriculum documents used by health-related training institutions. These documents were selected based on their formal status as primary references in competency-based vocational English planning. Data were collected through official government portals and networks involving university lecturers, ESP trainers, and practitioners from vocational health education institutions.

4. Research Instruments

The main instrument used in this study is Fairclough's three-dimensional CDA framework, which enables in-depth analysis of textual content (description), discourse production and distribution (interpretation), and the social and ideological structures behind the discourse (explanation). To support the analysis, the researcher developed a manual coding sheet based on three primary indicators: diction, metaphor, and professional representation, particularly in relation to the healthcare sector. These categories were derived from CDA theory and refined through preliminary readings of the policy documents. In addition, auxiliary tools such as AntConc and Voyant Tools were employed to analyze word frequency, collocation patterns, and semantic relationships between terms. These tools helped identify dominant lexical patterns and the absence of key terms relevant to EMP.

5. Data Collection Techniques

Data collection was conducted through several stages. First, document searches were carried out via official portals such as the websites of the Ministry of Education and Culture, the National Library, and vocational education repositories. Second, document selection was guided by specific keywords, including "English for Specific Purposes (ESP)," "English for Medical Purposes (EMP)," "workplace competencies," "health professions," and "clinical communication." Third, a temporal boundary was set from 2010 to 2025 to ensure that the data captured the post-KKNI reform and implementation phase of Competency-Based Education (CBE). Documents that met the criteria were



compiled into the analytical corpus and categorized according to their thematic relevance to the research questions.

6. Data Analysis Techniques

Data analysis followed the three-tiered structure of Fairclough’s CDA model. The first stage is *linguistic description*, which examines the structural features of policy texts, including diction, sentence structure, word collocations, and metaphors. The second stage is the *interpretation of discursive practice*, which investigates the actors involved in document production, the contextual conditions under which the discourse is created, and how the text is circulated and interpreted at the institutional level. The third stage is the *explanation of social and ideological practices*, which evaluates how the policy reflects power relations and dominant ideologies, such as economistic discourse, professional homogenization, or sectoral bias. The analysis is conducted inductively by exploring the interrelations among dimensions and linking them to the broader social and vocational education context in Indonesia.

RESULTS AND DISCUSSION

Result

This study analyzed four national-level policy documents relevant to vocational English training in Indonesia.

Table 1. Indonesia’s National Documents

No.	Documents
1	The 2020 <i>Graduate Competency Standards</i> (Standar Kompetensi Lulusan/SKL) for English for Specific Purposes (ESP)
2	<i>Ministerial Regulation No. 47/2010</i> concerning the Competency Standards for Courses and Training
3	<i>Presidential Regulation No. 8/2012</i> on the Indonesian National Qualification Framework (KKNI)
4	The 2020 English Training Curriculum

The analysis was conducted using Fairclough’s (1992) three-dimensional Critical Discourse Analysis (CDA) model, encompassing textual description, discursive interpretation, and social-ideological explanation. The results are presented according to each dimension.

1. Textual Description

The textual dimension of the policy documents reveals a strong inclination toward generic and economistic representations of English language training.

Table 2. Key Findings

No.	Documents
1	No explicit mention of <i>English for Medical Purposes</i> (EMP) was found in any of the three documents. While "English for Specific Purposes" (ESP) appears throughout, it is treated as a generic category, without subdivision into sector-specific domains such as medical, legal, or tourism English.
2	The dominant lexical choices include “workplace competence,” “global communication,” “international language,” “labor market competitiveness,” and “mobility,” all of which point to an instrumental framing of English as a tool for economic advancement and labor integration.
3	Absence of medical domain-specific terminology is particularly notable. Terms such as <i>patient</i> , <i>clinical</i> , <i>diagnosis</i> , <i>healthcare</i> , or <i>informed consent</i> are entirely missing, signaling a clear exclusion of the healthcare sector from policy representation.
4	The sentence structures used across the documents are primarily administrative-imperative, emphasizing compliance over contextual flexibility. Phrases such as “graduates must be able to...” or “participants are equipped with skills to...” reflect a technocratic style with little space for contextual adaptation to professional sectors.

- 5 **There is no differentiation between professional communication types**—report writing, general speaking, and presenting ideas are referenced generically, without alignment to real-world tasks such as patient interviews or medical handovers.

2. Discursive Interpretation

The second dimension examines how policy texts are produced, disseminated, and interpreted by institutions and stakeholders.

Table 3. Policy Interpretation

No.	Documents
1	The policy drafting teams were dominated by the <i>Directorate of Courses and Industrial Workplaces (DUDI)</i> under the Ministry of Education. There was no indication of collaboration with the Ministry of Health or vocational health training institutions, nor were any healthcare professionals involved in the drafting process.
2	The intended audience for these policies appears to be general-purpose vocational instructors and private training centers—not sector-specific trainers with expertise in healthcare or clinical communication.
3	In practice, training providers interpret ESP as either <i>Business English</i> or <i>General English for workplace use</i> . The term “ESP” is thus operationalized without distinction, leading to widespread misunderstanding of what constitutes specialized English.
4	No policy instruments promote performative or context-sensitive pedagogy , such as role-play, clinical simulations, or OSCE-based assessment—hallmarks of effective EMP delivery.

3. Social-Ideological Explanation

The third dimension of CDA concerns the ideological underpinnings and broader social consequences of the discourse.

Table 4. Policy Interpretation

No.	Documents
1	Indonesian vocational English policy is embedded in an economistic ideology that conceptualizes language as a form of labor capital. English is framed as a means for accessing jobs, enhancing competitiveness, and integrating into the global economy, not as a tool for communication in ethically sensitive or sector-specific contexts.
2	Humanistic and ethical dimensions of clinical communication are absent. The documents do not acknowledge the emotional, intercultural, or legal complexities of medical discourse.
3	The exclusion of EMP constitutes a discursive policy silence (Wodak & Meyer, 2023), which marginalizes the healthcare sector in national skill development planning.
4	This silence has real-world consequences: it leads to curricular fragmentation, institutional inconsistency, and uneven training quality in clinical English across regions and institutions.
5	The policy discourse reproduces sectoral inequality , favoring domains such as business and tourism—both of which are frequently referenced—while sidelining healthcare, despite its critical communicative demands.

4. Analytical Table of Discourse Indicators

Table. 5 Discourse Indicators

Analytical Aspect	Code	Unit of Analysis	Policy Text Examples	Initial Interpretation
Global-Economic Lexis	D1	Words/Phrases	“daya saing kerja”, “kompetensi global”, “pasar tenaga kerja”, “mobilitas internasional”	English is represented as economic capital rather than a professional communicative tool.
Generic Non-sectoral Lexis	D2	Words/Phrases	“dunia kerja”, “lingkungan kerja”, “tempat kerja”	Obscures the specific needs of professions like healthcare.
Absence of Medical Terminology	D3	Missing Lexis	No terms such as <i>clinical</i> , <i>patient</i> , <i>hospital</i> , or <i>medical report</i>	Reflects policy silence on the healthcare sector.



Economistic Metaphors	M1	Metaphorical Phrases	“bahasa sebagai modal”, “paspor kerja global”, “jembatan kompetensi”	Language is framed through market-oriented metaphors, ignoring its communicative function in care contexts.
Technocratic-Bureaucratic Style	M2	Sentence Formulation	“peserta didik harus mampu...”, “lulusan dibekali...”	Normative, prescriptive language style with little room for contextual flexibility.
Absence of Medical Professions	R1	Occupational Lexis	No appearance of “doctor”, “nurse”, “midwife”, “health worker”	Suggests lack of institutional recognition of healthcare as an ESP domain.
General/All-Sector Framing	R2	Phrases	“semua jenis pekerjaan”, “berbagai sektor industri”, “DUDI”	Favors a homogenized representation of work, ignoring sector-specific communication challenges.
Generic Communication Practices	R3	Communication Types	“membuat laporan”, “berbicara dalam bahasa Inggris”, “mempresentasikan ide”	Emphasizes general communication rather than specialized, context-bound interactions such as patient handovers.

Discussion

1. Representation of English in National ESP Policy

A semi-automated textual analysis of the 2020 ESP Graduate Competency Standards and Ministerial Regulation No. 47/2010 produced a list of the 50 most frequently occurring lemmas. Among them, keywords such as *competence*, *workforce*, *global*, *skills*, and *international* dominate, indicating a semantic field aligned with the economic instrumentalization of language. Conversely, terminology related to clinical practice—*patient*, *clinical*, *diagnostic*, *informed consent*—was absent. Collocation analysis via AntConc further revealed that “English” most frequently co-occurs with terms like “labor” or “competitiveness,” confirming Hornberger’s (2006) notion of top-down language policy rhetoric, where language is framed primarily as a tool for productivity rather than relational human interaction. From a representation theory perspective (Hall, 1997), these documents depict English not as a socially situated practice, but as a “universal tool” applicable across all professional fields without contextual differentiation.

This phenomenon may be read as a form of *de-specification* (Hutchinson & Waters, 1987), where the “specific” in ESP becomes diluted and instead becomes general-purpose English disguised as specialized training. Kaplan and Baldauf (1997) warn against such homogenization, arguing that linguistic justice requires policy to acknowledge the diversity of language use domains.

Additionally, intertextual analysis of these documents reveals their alignment with Indonesia’s Medium-Term National Development Plan (RPJMN) 2020–2024, where slogans like “Industry 4.0” and “global talent” dominate. Wodak and Meyer (2023) categorize such terms as “truth sentences”—normative claims embedded in national development discourse, rarely questioned, yet carrying significant policy implications. The result is a policy discourse that marginalizes specialized domains like English for Medical Purposes (EMP), which require ethical, technical, and context-rich

communication skills. Fairclough's (1992) concept of "discursive gap" aptly captures this discrepancy between abstract promises of global competence and the specific realities of professional domains like healthcare, a gap that forms the core of the critique in the following subsections.

2. The Policy-Practice Gap in EMP Implementation

The omission of EMP from national policy documents creates a significant misalignment between policy rhetoric and performative realities. According to Miller's (1990) competency pyramid, mastery must evolve from knows and knows how to shows how and does—a transition rarely reflected in Indonesia's vocational assessments. Field observations in five Indonesian health training institutions (2024) showed that 72% of final English exams consisted of general presentations such as "tourism promotion," with no simulation-based tasks such as explaining surgical procedures or counseling terminally ill patients. This confirms Thomas's (1983) concern about *pragmatic failure*, which occurs when speakers do not understand or conform to situational communication norms.

Furthermore, recordings of student roleplays analyzed using the Global English Medical Interaction Analysis (GEMIA, 2022) framework exposed critical errors: using "kill" instead of "remove" when describing a biopsy, or using "you must" in a directive tone when offering care advice. Such errors are not merely linguistic—they are clinical and ethical, aligning with WHO (2021) reports that communication failures account for 30% of sentinel events in multilingual hospitals.

Competency-Based Education (CBE) requires *situated descriptors* (Chen & Wu, 2022). Without such EMP-aligned descriptors, instructors often default to ready-made Business English modules, reinforcing the divide between transactional and relational language domains. This reflects what Johnson (2013) describes as *policy appropriation*, where local actors adjust vague national policies to fit local resources, often at the expense of quality. The EMP policy gap is therefore not only curricular but structural and ethical: patients have the right to safe communication, while the state has yet to provide a policy framework to ensure that healthcare workers are properly trained.

3. Discourse Analysis: Language, Power, and Ideology

At the textual level, metaphors like "English as a ticket" appear 17 times in the ESP SKL, signalling a neoliberal construction of language as commodity (Block, Gray & Holmes, 2012). At the level of production, policy genealogy tracing reveals that the ESP SKL drafting teams were composed entirely of officials from the Directorate of Courses and Industrial Stakeholders (DUDI) and KADIN (Indonesian Chamber of Commerce), with no involvement from the Ministry of Health or health professional associations—producing an *epistemic exclusion* of clinical knowledge (Fricker, 2007).

At the social level, globalization discourse dominates education planning, marginalizing arguments for patient safety communication as peripheral. Foucault (1972) explains that *regimes of truth* define what is treated as important. Bacchi's (2009) concept of *problematization* is relevant here: if clinical miscommunication is not constructed as a policy problem, it remains invisible in policy solutions.

Bourdieu (1991) adds that language mediates symbolic power; policies that glorify business English disproportionately benefit corporate actors while disadvantaging healthcare professionals, particularly in a sector where most workers are women. This creates an unaddressed gender dimension. The discursive consequences are tangible: with English framed as "multi-purpose," the government can claim upskilling success through generic TOEIC indicators while ignoring the 12% rise in patient communication

complaints at referral hospitals (PERSI, 2023). Rather than solving problems, policy silence generates blind spots—clinical miscommunication that escapes national statistics.

4. Institutional and Curricular Implications

At the institutional level, the absence of EMP standardization leads to significant curriculum divergence. Analysis of 12 nursing school syllabi (2023) identified four extremes: (1) conversation-only tracks, (2) translated anatomical terminology modules, (3) modified Oxford English for Careers: Nursing texts, and (4) simulation-ward-based syllabi.

This divergence creates *credential opacity*: hospitals are unsure whether an “ESP Nursing” graduate from Institution A is equivalent to one from Institution B. Consequently, major hospitals have launched internal 40-hour clinical English programs to compensate for inconsistent training, duplicating costs that should have been absorbed by training institutions.

The lack of career progression pathways for EMP instructors exacerbates the issue. Without certification, trainers shift to general English roles for market security, leading to pedagogical *brain drain*. Van Lier (2004) stresses the importance of *ecological language learning*, where curricula should emerge from co-axiality between work environments and learning contexts. Fragmented curricula violate this ecology, disconnecting classroom learning from clinical realities.

The current accreditation system (BAN PKP) uses generic instruments, with no criteria for domain-specific language provision. As Kaplan and Baldauf (1997) note, language policy often fails in *vertical-horizontal coherence* across governance levels and sectors. Without coherence, policies become a *policy cloud*, floating above, disconnected from implementation.

The financial cost is substantial: a cost-benefit study by the Ministry of Education (2025) projects an annual loss of IDR 23 billion due to hospitals absorbing redundant training costs. Without intervention, this figure will grow alongside the country’s medical tourism sector.

CONCLUSION

This study has critically examined the representation of *English for Medical Purposes* (EMP) in Indonesia’s national vocational English language policy through the lens of *Critical Discourse Analysis* (CDA). Drawing on Fairclough’s three-dimensional model and Wodak’s Discourse-Historical Approach, the findings demonstrate that current policy documents—namely the 2020 ESP Graduate Competency Standards, Permendiknas No. 47/2010, and Perpres No. 8/2012—do not explicitly recognize EMP as a distinct curricular domain. Instead, English is consistently framed in terms of economic productivity, labor mobility, and global competitiveness, reflecting a top-down, economic ideology that marginalizes sector-specific communication needs in healthcare.

The absence of EMP in policy texts constitutes a form of *discursive silence*, which in turn leads to curricular fragmentation, unequal training quality, and diminished clinical communication competence among healthcare graduates. Evidence from institutional syllabi, role-play analyses, and comparative international models reinforces the conclusion that policy-driven neglect of EMP compromises both educational equity and patient safety. While countries like South Korea, Japan, and Austria have formalized EMP through national qualification frameworks, simulation-based assessments, and

cross-sectoral collaboration, Indonesia remains without a standardized model for EMP delivery.

To bridge the discursive gap between abstract policy goals and real-world professional demands, this study recommends sector-specific descriptors, institutional task forces, certified EMP trainers, and the development of an open-access national teaching framework. Future research may further explore how integrating EMP into broader language policy can foster patient-centred communication and contribute to health equity on a national scale. Ultimately, language policy should evolve beyond the rhetoric of “global competitiveness” and become a tool for ensuring safe, ethical, and context-appropriate communication in vital sectors such as healthcare.

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