Integrating isiXhosa into clinical skills to address the linguistic landscape of the Western Cape

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Abstract

The Language Plan of the University of Cape Town (2001) suggests that language is integral to our social and academic discourse at all levels including communicating and learning. In an attempt to live up to the Language Plan and be responsive to the linguistic needs of the Western Cape community, the Medical School in the Faculty of Health Sciences and the African Languages Department developed isiXhosa in Health Sciences Programme. The programme aimed at developing students' multilingual awareness and multilingual proficiency skills as an innovative programme. This programme, simultaneously gives students an opportunity to gain access to content and language. Although there are still several challenges in getting all students to achieve the desired proficiency levels in the target language, the value of the programme for students cannot be ignored. Research conducted through interaction with students and field notes during clinical observation reveals the significance of being able to communicate with the patient in the language of the patient. Of importance is being able to gather information in isiXhosa beyond classroom content and using that information to strengthen their learning of the language (isiXhosa). Different types of pedagogical practices are used to teach the language integrated into clinical skills. This study aims to show clinical benefits of integrating isiXhosa into repertoire of dominant Western Cape languages such as English and Afrikaans and which have historically benefited from use in Universities in health Sciences field to promote better communication between patient and health science professional. It will be conducted through observing student participation and performance during clinical skills integrated session where they interact with patients using the target language.

Introduction and contextual background

The importance of multilingualism in South African higher education is widely acknowledged in government language policy documents such as the Language Policy for Higher Education (LPHE) (DoE, 2002) and the Ministerial report for the Development of African Languages (DoE, 2005). The LPHE (DoE, 2002) states that multilingualism should be promoted in higher education to ensure access into languages of the people in the region particularly for public service purposes. Accordingly, provinces developed language policies or language plans that are coherent to their multilingual realities.

Similar to other regions, the multilingual reality of the Western Cape is evident in workplaces such as hospitals, where health care professionals might likely use Afrikaans, isiXhosa and/or English when communicating with their patients or colleagues. This paper is concerned with health care professionals in training, who are students of medicine. When medical students attend clinics most of the patients they see are not fluent in English or do not know English at all. Where medical students speak a different language to that of their patient, misunderstandings may result in misdiagnosis. For example, when another member of the health care professions, for example, a nurse who speaks the same language as the patient, interprets for the medical student the condition of the patient, it might easily be misinterpreted. Furthermore, to explain procedures and routines required for treatment, there is a clear need for those conveying these procedures to communicate in the language of the patient (Wyrely-Birch, 2006: 72). It is for these reasons that UCT has made it mandatory for their medical students to learn isiXhosa and/or Afrikaans, the dominant languages of the region.

Patients whose mother tongue is not English or Afrikaans appear to encounter difficulties in expressing the illness bringing them to a public hospital or clinic in the Western Cape where the majority of doctors speak a different language to that of the patient. This restricts them from providing a detailed account of the illness. Health practitioners are also restricted when language is a barrier. As a result cleaning staff or health practitioners who speak isiXhosa are often called to interpret. Although this appears plausible, meaning could easily be lost in translation. In an attempt to deal with the language the University of Cape Town undertook to make it compulsory for students studying medicine to learn isiXhosa as one of their subjects. This will hopefully bridge the language gap between patients and doctors.

Method

The study employs conversational analysis. Conversational analysis is an eclectic approach used in analysing data collected. It allows a complete synthesis of the findings. This means the researcher is able to analyse micro issues in conversation as explained by Eggin and Slade (2004). One is able to deduce each appropriate turn in a conversation. It will also make use of interviews which yield more towards qualitative research as interviews allow participants construct their reality Creswell, (2003). A researcher employing qualitative research will have to faithfully report the realities that rely on voices and interpretations of participants (Creswell, 1994: 4). A Conversation Analysis approach is also a useful approach for data analysis and discussing findings. Eggins and Slade (2004), posit that conversation should be viewed as a generative, turn taking mechanism aimed at maintaining the flow of talk. The approach is grounded in conversational organization as in the case of interviewing students concerned. Employing aspects of qualitative study, the study will prove whether students appear confident, anxious and/or learning anything during oral assessment. This is based on assumptions that students who crawl through the test might appear nervous, and those who are confident might be those who do extremely well. Findings will tell us whether oral assessment enhances or encourages students' understand of isiXhosa and if responses appear contradictory, we will investigate further in following studies.

Data collection

Data were collected through conducting interviews with a group of 40 students doing second year. The groups were in sub-groups of eight, each sub-group dealing with a question. They were non-speakers of isiXhosa. They had been less exposed or not exposed to isiXhosa, but had to learn it for purposes being able to communicate with patients. The curriculum involves the language of examination and chest related ailments whereby a group of four students examined one patient. The process involved introducing students to terms such as*, jonga phantsi, jonga phezulu, phakamisa isandla, goba idolo, phefumelela ngaphakathi, phefumelela ngaphandle.*

Semi-structured and structured interviews were conducted. Student observation occurred during clinical visits.

Research Questions

In order to conduct structured and semi-structured interviews the following questions were asked: **(i)** Does integration of isiXhosa into clinical skills improve student competence in isiXhosa; **(ii)** Are there linguistic benefits in learning isiXhosa through an integrated approach?

Observations

Observation is a research strategy that that assists the researcher to respond to research questions underpinning the study. It assists the researcher to have first-hand information on the manner in which students cope with the demands of language integration into clinical skills (Mouton, 1999). The most difficult part was attempting to remain an outsider as it is a norm for a researcher to subconsciously loose such a status as time goes by. In this particular study the loss of observer status was expected since the researcher later conducted the intervention on using Observations was conducted during mock interviews helping students familiarize themselves with the language. Observing during lectures assisted in understanding the classroom atmosphere and the extent to which learners are able to communicate in isiXhosa. All observations were recorded to assist in giving full account of data collected at the analysis stage. The purpose of note taking was to check whether there is a reflected relationship between learners' interview responses and the processes of oral assessment.

Interviews

For the purposes of this study structured and semi-structured questionnaires will be used to guide the interviews process. Interviews are chosen as a method of acquiring the desired information (Giles, 1993). Structured interviews are essential for face-to-face interviews where questions are asked against a coded response. The semi-structured interviews refer setting up questions around themes that seek to guide the interview process allowing the interviewer to adapt, modify and add to set questions as needs arise (Cousins, 2009).

Language integration

Literature on integration shows that students learn second language when integrated into content because it appears to serve purpose and tends to encourage student enthusiasm towards learning a new language. Scholars such as (Long and Robinson, 1998) appear to encourage integration of language into content since it appears to eliminate the notion of categorization between language and content. Instead of seeing language as a separate entity, it is seen as part of the content hence it is of significance in being part of studying towards becoming a doctor. Language integration also allows the social and intercultural aspects of the communicative ability to be adapted according to different contexts, purpose and language users. Understanding and using the embedded cultural codes which form part of the speech in isiXhosa are included in language integration. These could be in the form of markers of politeness, intonation and expression. Hence, research conducted by (Doughty and Williams, 1998) emphasises the form-focus intervention since it brings out the purpose of language integration. Form-focused intervention occurs when conversational interaction becomes modified to achieve message comprehensibility, and does so in ways that draw the learner's attention to relationships of L2 form and meaning, through a *focus on form* (Doughty and Williams, 1998; Long and Robinson 1998). Focus on form, as defined by Long & Robinson (1998), is viewed as "an occasional shift in attention to linguistic code features which are triggered by perceived problems with comprehension or production". Other researchers have used the term in ways that emphasize its attentional component. A focus on form need not be triggered by communication problems, but might anticipate them through learner directed models (Doughty and Williams, 1998).

In this context, form-focused intervention can occur within negotiation, as the need to repair conversational breakdowns brings interlocutors to shift attention from a sole emphasis on the exchange of message meaning to the perceptual or structural shape that encodes the meaning. This shift of attention is in keeping with the meaning of Long and Robinson's focus on form (1998). Not all negotiation involves such a focus on form. For example, one speaker might fail to interpret the meaning another interlocutor intended due to differences in message content expectations or culturally grounded world views. Such misinterpretation might lead to a negotiation of message meaning, even though the linguistic form of the message is acceptable, appropriate, and not the focus of the conversational repair. Focusing on form during integration appears plausible. However, language integration should adapt to more than form and meaning making.

Although the integration model appears favourable, it has been discussed and criticised by scholars such as Brinton et al. (1989: vii). They posit that its implementation poses a challenge for adequate integration (Brinton et al., 1989: vii).

Amongst other issues is the pace at which isiXhosa requires to be taught and decisions about selecting content. The question about selecting content, how such content will be integrated with language, and how the resulting language skills students acquire will be directly linked to the objectives or reasons for the programme often arise, (i.e. cultural, cognitive, content, language and environment). It is difficult to immerse students who have less exposure to the language in integrated sessions as a result a lot has to be considered.

One of the difficulties is caused by the fact that, during patient examination, students come across a new set of language, terms and vocabulary that has not been used in class. This exposure compels lecturers to teach the newly found language on the spot. A process that takes away their focus on practising what they learnt but forced to focus on the acquired languages.

Language integration: a strategy for learning

Integrating isiXhosa into the clinical language required by medical students is of significance to ensure that there is a patient-doctor mutual understanding during examination. This clinical language requires students to have knowledge about the language of examination, instructing the patient to follow certain things and execute certain tasks according to the doctor's instructions.

Teaching a second language calls for an approach that assist students to practice. Hence, the use of an interactive approach which employs doctor patient interviews. Putting emphasis on integrating isiXhosa into the course content; conducting a three stage -assessment in isiXhosa, using the language of examination in group work and offering advice in mock doctor-patient interviews. The strategy hopes to develop functional bilinguals, who according to Valdes (1999) are individuals who have developed a fairly advanced level of proficiency but still producing frequent errors. The strategy assists students to see isiXhosa as the integral part of their course. Also, this is an attempt to alleviate the tendency of learning the language by memorizing the interview procedure. Memorizing the language used in procedures helps students pass exams without being conversant in the language. This makes it difficult to reflect fully on the effectiveness of the course and its development of isiXhosa. It is for this reason that we adopt a communicative approach to teaching so putting emphasis on communication as opposed to mere traditional lectures. Increase student exposure by doing more clinical practice in hospitals where isiXhosa is the dominant language (Mangena, 2003). Increase student access to online materials such as DVDs and computer based programmes which are designed together with the Multilingual Education Programme at UCT.

Although the study materials are adapted to the language of medicine, teaching the standardized form of isiXhosa becomes a challenge. It further places an intellectual demand on students particularly those who are not exposed to isiXhosa. The integrated content cannot be simplified to a level of conversation only. Key terms that cannot be taught for they are fundamental to the context remain unable to simplify. Students have to cope with learning those (terms) by heart and constant practicing. This could appear problematic since learning a second language requires a greater exposure to rules and practice focusing on form can be used to monitor progress and understanding.

Furthermore, teaching the standardized form appears to introduce students to a 'new' language that is foreign to health practitioners (patients, doctors and nurses). So, sometimes they have to explain themselves to isiXhosa speaking patients because they (patients) can simply not understand when students speak the standardized variety. Again, with the limited vocabulary that the students have, it becomes difficult for them to explain beyond what they are taught. For example, we would teach students to refer to diabetes as "isifo seswekile" while in the hospital context it is referred to, "iswekile" (sugar), "ixamba' (ten kilograms of sugar which in this context indicates the amount of sugar the patient has) or "idaydayi" a word derived from "di" in diabetes. Use of these varieties marks a significant functional language for patients, doctors and nurses. So, this compels language lecturers to constantly review the curriculum reconciling terms and the vocabulary, the standardized form and the communicative form continuously, drawing from the clinical jargon (Madiba, 2001: 72).

Challenges of integrating isiXhosa

Students in the medical school programme are required to learn isiXhosa as one of the languages which form part of their studies. The structure of the course is such that students should be able to conduct a three stage interview with patients. These stages are, taking the patient's personal information, social history and conducting the actual diagnosis. It is during the interview process that students reflect on their linguistic short falls. The interview process does not only require them to learn the communication language but to also understand key terms central to the diagnosis. This, places a huge language demands on students because most of them have not been exposed to the language.

Integrating isiXhosa into the content seems to compel students to learn through rote learning, prepare themselves for the test and maybe focus only on the questions asked during the doctor-patient interview. Learning the questions without fully understanding patients' responses does not appear to ensure students ability to communicate fly with the patient. One of the reasons is that, students have never

been taught isiXhosa during primary and high school. Those that learnt isiXhosa did it as a second or third language which did not give them a stronger foundation to learn the structure and typology of the language. This becomes a predicament for them in that should they have done it while at school, at university they could only be introduced to the language of medicine. Without doubt, this would enable them focus on the language relevant to the needs of the medical context.

Secondly, some of the students studying medicine are from outside South Africa so, isiXhosa becomes a foreign language. The form, pattern and the typology of the language can be different from theirs. They have to put an extra effort in familiarizing themselves with the language. Lastly, the language which integration imposes on students is difficult to cope with. The nature of the course content is such that language development revolves around key terms that cannot be written otherwise to meet the linguistic level of the students.

Staff matters

The scarcity of lecturers in the language field and staff workloads creates a difficulty for lecturers to cope. The large numbers that are administered by a few lecturers creates a tension between the university's language plan and classroom practice (University of Cape Town, 2001). This puts strain on emphasizing some of the significant of learning isiXhosa such as cultural diversity. The cultural diversity embodied by the language requires more attention in the medical field. A doctor patient dialogue which displays respect and use of appropriate language is highly regarded. The old man or woman might show respect and affection by referring to the doctor as (*Gqirha mntwana'm-doctor, my child)* while the doctor will say *"ewe mama-yes mama" "uyaqonda mama-do you understand mama*? By virtue of being the knowledgeable one, the doctor could easily say "*yiza ndikuxilonge-come let me examine you"*, but he or she would rather use a tone of respect and assurance, *ndicela ukukuxilonga mama/tata-I would like to examine you, mama/tata).*

This respect is demanded by culture embodied in the language. It is recognition that language is one of the most powerful transmitters of culture (Goduka, 1991). Although in such a context language seems to be a social practice, recognising cultural diversity needs to be managed and be part of the language in the health practice. Communication in second language can be complicated by cultural issues that one has to be aware of, particularly in the medical field. However, managing cultural diversity ensures an enabling environment for patients who speak isiXhosa as his or her mother tongue (Meier and Hartell, 2009) with less sufficient linguistic expertise in other languages of the region like English and Afrikaans.

Embracing and managing cultural diversity would be like “training’ on one hand and education on the other hand and is critical to ensure that speaking the language of the patient creates a platform for language development for learners. Patients offer students more language than what is taught in the classrooms (Winberg, 2005). In cases where students do not understand, the patients make an effort to explain in either very ‘broken’ English or by means of interpretation. In the process the students themselves learn new vocabulary which they always verify in class for thorough understanding.

Benefits of language integration: Observations

Findings made from observations and interviews indicate that students see benefit in learning isiXhosa through an integrated approach. Since the language is part of the lesson, there is no extra burden to learn grammatical rules separately from content. This makes conversation between the patient and themselves easier. Patients become more involved, attentive to instructions and commit to compliance. Discussions flow with ease and trust seems to develop. Patients open up easily about the sickness and patients seem to feel empowered when they communicate to the patient in his/her language.

Another interesting observation to note is that, during integrated sessions, students appear to have greater awareness about the amount of language skills they have learnt in class. Often, they seem to underestimate their understanding of the language and language integration gives them an opportunity to see that they are progressing relatively well. They are able to construct a valuable conversation with the patients and are also able to probe about illness to a certain level, although, we cannot claim that they have mastered the language.

Benefits of language integration: Student perspective

Students interviewed on whether there is a benefit in learning isiXhosa agree that there is benefit. However, a lot of work needs to be done to improve ensure the effectiveness of the course. The course materials need to be simplified to ensure student friendliness. Students see the benefits of learning isiXhosa or the need for learning isiXhosa highlighted in the paragraph above, during visits to the clinics, old age homes and public hospitals that students. These visits inform the students how much language they have acquired or they need to communicate effectively with their respective patients. For many, it becomes a mirror to look at themselves and a motivator to adopt a positive attitude and willingness to learn the language. This often happens at third year level when students are highly exposed to patients who are

English non-speakers. The exposure to patients who speak isiXhosa encourages them (students) to participate fully during lectures. This means, paying attention in class, co-operate during lecturers, asking questions and taking part in group work.

Conclusion

The aim of this paper was to show clinical benefits of integrating isiXhosa into repertoire of dominant Western Cape languages such as English and Afrikaans and which have historically benefited from use in Universities in health Sciences field to promote better communication between patient and health science professional. It was conducted through observing student participation and performance during clinical skills integrated session where they interact with patients using the target language. The findings of this paper therefore indicate that for effective language integration, learners should be exposed to isiXhosa during their schooling years. Bringing isiXhosa to early ages of schooling would ensure that they are exposed to the structure of the language, typology and form which are fundamental to learning isiXhosa. Lack of exposure and immersion at university places a demand, on both students and lecturers (Vygotsky, 1978). Students only begin to learn about the structure and language form when in fact they should be focusing on the language of medicine. Should this be implemented it would ensure that understanding is accelerated and learning is progressing. Furthermore, the vocabulary and terms used should be cognizant of the jargon used in the clinical context since standardized terms appear to create a communication barrier between the students and the patients. The clinical context has its own jargon so our curriculum and study materials should rather speak to what is already happening.

Regarding students with absolutely no exposure to South African languages, coming from outside South Africa, they should be immersed into a communication language programme that will familiarize them with the basics of the language before they are introduced to structure and form. Presumably, the ability to communicate basically in the language could encourage them to learn more about typology thereby improving their communication. Amongst other essential components of language learning is the teaching strategies. The teaching strategies should strive to enhance interaction in the classroom and help develop student communication in the target language. Learning big chunks of information and simple phrases through rote learning does not help students learn the language effectively.

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