CREATING CONDITIONS FOR STUDENT SUCCESS

**Social justice
perspectives from a
South African university**

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COMMUNICATION IN MULTILINGUAL HEALTHCARE CONTEXTS

TRAINING TOWARDS PATIENT-CENTREDNESS

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INTRODUCTION

The aim of this chapter is to demonstrate the importance of competency in communication skills for students, with a focus on preparing healthcare professionals for the workplace. Communication is an essential skill in the field of medicine and health sciences. Without good communication skills, healthcare professionals are unable to assist patients effectively. It is thus necessary for healthcare professionals to acquire communication skills in the language of their patients by means of effective communication programmes. This chapter critically considers the contribution of such a programme to the development of communication as a critical skill for healthcare professionals which is a prerequisite for patient-centredness.

In the chapter, I firstly argue that communication is a critical skill for healthcare professionals. I then go on to explain how the communicator role of the CanMEDS framework has been adopted as one of the graduate attributes at the Faculty of Medicine and Health Sciences of Stellenbosch University. Having explained the theoretical framework, the research problem is discussed, followed by an outline of the research design, research methods and participants. Thereafter, the results of the study as well as possible implications are presented.

COMMUNICATION AS CRITICAL SKILL

Communication, which can be defined as a process through which human beings try to reach shared understanding, is an important part of people's lives. It is central to the process of meaningful interaction amongst people. Without the effective exchange of information, ideas, emotions and opinions amongst people, mutual understanding cannot be accomplished (Emanuel 2007).

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Healthcare professionals work with patients in a variety of healthcare contexts, and effective communication is essential when healthcare professionals enquire about patients' health problems, discuss possible treatment, and manage the plan of treatment (Wynia & Osborn 2010). Stewart (2001) suggests that communication is more effective when it is responsive to the needs, values and preferences of patients (Almutairi 2015). It is therefore important that patients receive health services through competent and effective communication (Divi, Koss, Schmaltz & Loeb 2007). To improve communication, the healthcare professional and patient need to cooperate and coordinate their communication needs and skills (Mauksch, Dugdale, Dodson & Epstein 2008; Street, Gordon & Haidet 2007).

Hence healthcare professionals have a responsibility to master effective communication as an essential skill. This includes being aware of the required communication features that should be present during consultations in order to build a positive relationship between healthcare professional and patient. Communication does not only rely on what is being said, but also on the way in which it is being said, incorporating both verbal and non-verbal skills (Roberts & Bucksey 2007). In the context of health care, communication skills include being gentle when giving information and providing emotional support through verbal behaviours such as greetings, open-ended and encouraging questions, and non-verbal behaviours such as facial expressions and gestures (Pinto, Ferreira, Oliveira, Franco, Adams, Maher & Ferreira 2012). Furthermore, being able to explain in different ways, listening carefully and being able to adapt are crucial. Language is powerful, and therefore, as David Abram wrote: "Only if words are felt, bodily presences, like echoes or waterfalls, can we understand the power of spoken language to influence, alter, and transform the perceptual world" (Abram 1997:89). This statement encapsulates many of the powerful features of language. By improving their communication skills, healthcare professionals will be able to engage better with patients by listening more attentively to what patients have to say, asking the right questions and being sensitive to their emotional concerns. In this way, the cooperation of patients will be facilitated and, in turn, patient-centred care will be enhanced (Pinto et al. 2012), because speaking the same language can bring people together. In multilingual healthcare contexts, particularly when healthcare professionals and patients speak different languages, this becomes challenging.

One of the ways to address the language and cultural barriers in the South African healthcare context is to promote multilingualism amongst healthcare professionals by providing courses for additional language acquisition by these professionals. However, according to Maseko and Kaschula (2009), few language programmes equip student-professionals effectively with communicative skills in the context

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of their profession. Where these language programmes do exist, they are often generic in nature and usually focus on the structure of language and not on specific communication needs. Consequently, many of the healthcare professionals produced by medical schools are communicatively incompetent in the languages of the patients they serve (Maseko & Kaschula 2009). Hence it is crucial for health professions training institutions to implement language curricula that contain content and communication skills specific to the needs of the students. The focus should be on communication in a clinical context that could bridge the language and cultural barriers that contribute towards constraining the provision of effective health care for all communities.

Since learning a new language as an adult is not easy, an environment in which students are able to acquire a basic understanding of the language and the culture of patients should be created (Schlemmer & Mash 2006). Expecting healthcare professionals to be fully bilingual or multilingual is unrealistic; language programmes should rather aim at providing healthcare trainees with the necessary language and cultural knowledge and vocabulary in order to be able to communicate effectively with their patients.

GRADUATE ATTRIBUTES AT THE STELLENBOSCH UNIVERSITY FACULTY OF MEDICINE AND HEALTH SCIENCES

It is evident that healthcare professionals' communication in the language of patients could have a positive effect on the quality of health care. Developing communication skills in the context of health sciences further contributes to the personal and professional development of healthcare professionals. Professionalism in the health sciences includes competency in clinical skills, but also covers a wider spectrum of skills. This is illustrated by the CanMEDS Roles Framework initiative (Frank 2004). In the early 1990s, Fellows of the Royal College of Physicians and Surgeons of Canada, with support from the Associated Medical Services, developed a competency framework, i.e. the CanMEDS framework, for specialist physicians. The CanMEDS framework was formally accepted and approved by the Royal College in 1996 and subsequently updated in 2005. This framework describes the key abilities needed for a healthcare professional to optimally meet the health care needs of the population, and it is globally implemented and applied to guide medical education (Frank & Vanoss 2007; Richardson et al. 2014).

The CanMEDS framework was also adapted in order for the key and enabling competencies to be applicable to education and training of healthcare professionals in a South African medical context (Van Heerden 2013). More specifically, the CanMEDS framework was used to inform undergraduate health sciences education

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as well as the allied health professions training at Stellenbosch University's Faculty of Medicine and Health Sciences (FMHS). At FMHS, this framework also serves as graduate attributes. The framework covers the healthcare practitioner's various roles as professional, scholar, health advocate, leader and manager, collaborator and communicator. These graduate attributes were adapted for undergraduate training and are implemented in the five undergraduate training programmes (i.e. Medicine, Occupational Therapy, Human Nutrition, Physiotherapy, and Speech-Language and Hearing Therapy) of the FMHS. Figure 8.1 illustrates the seven roles of the CanMEDS framework. For the purpose of this study, the focus was on using the communicator role with its competencies as a guide to inform the development of communication skills of healthcare professionals. This role is discussed in more detail below.

FIGURE 8.1 The CanMEDS framework (Source: Adapted from the CanMEDS Physician Competency Framework in Frank 2004)

THE COMMUNICATOR ROLE OF HEALTHCARE PROFESSIONALS

In the CanMEDS framework, the communicator role was designed to depict the essence of physicians as communicators, and to effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter. This framework with its key and enabling competencies was

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adapted and refined to meet the needs of the allied health professions programmes at FMHS. For this purpose, the communicator role was defined as “healthcare professionals who effectively facilitate the carer-patient relationship and the dynamic exchanges that occur before, during and after interventions” (FMHS 2013:5). The key competencies of the communicator are as follows (FMHS 2013:5):

- Develop rapport, trust and ethical therapeutic relationships with patients, families and communities from different cultural backgrounds.
- Accurately elicit and synthesise relevant information and perspectives of patients and families, communities, colleagues and other professionals.
- Convey relevant information and explanations accurately and effectively to patients, families, communities, colleagues and other professionals as well as statutory and professional bodies.
- Develop a common understanding of issues, problems and plans with patients/clients, families, communities, colleagues and other professionals to develop a shared plan of care/action.
- Convey effective and accurate oral and written information about a clinical encounter.

In order to achieve the outcomes as described by the FMHS (2013), the language use of the healthcare professional and the patient in this specific context must be clear to both parties. Where healthcare professionals are not able to consult patients in their (the patients’) language, difficulties are experienced with understanding patients, making themselves understood, and asking questions (Levin 2004, 2006; Schlemmer & Mash 2006), and language barriers occur (Levin 2011).

However, for healthcare professionals, communication is much more than merely using proper vocabulary and correctly applying grammatical structures and conventions. It is about understanding cultural differences, and about building relationships and trust by using appropriate communication skills. It is also about understanding a person, and thus focusing on the importance of patient-centredness and, in turn, patient-centred communication. Epstein, Franks, Fiscella, Shields, Meldrom, Kravitz and Duberstein (2005) explain that the healthcare practitioner with patient-centred communication skills could help patients to understand their condition and could involve them in choices by communicating effectively.

Patient-centred communication must enable shared decision-making and effective dynamic interactions with patients, families, caregivers, other professionals, and other relevant persons. It is essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care. Whereas effective patient-centred communication is critical

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for optimal patient outcomes (Frank 2005), poor communication can lead to undesired outcomes such as unsafe medication use and poor health practices, and can place patients at risk of medication errors (Schillinger, Wang, Rodriguez, Bindman & Machtinger 2006).

PROFILE OF THE STELLENBOSCH UNIVERSITY HEALTHCARE PROVIDER

Competent healthcare professionals are a *sine qua non* for an effective healthcare system. Competence in the context of health care refers to a healthcare professional's suitability for a specific discipline and is focused on the knowledge, skills and attitudes that a healthcare professional should develop (Mentkowski 2000; Lichtenberg, Bebeau, Nelson, Smith, Portnoy & Leigh 2007). Achieving competence is a developmental process which requires gradual progression towards the integration of the acquired knowledge, skills and attitudes (Zane 2008).

In order to apply the acquired knowledge, skills and attitudes successfully, it is important for healthcare professionals to engage effectively with both patients and other healthcare professionals within the healthcare context. In a multilingual context the development of effective communication skills, including second- or third-language acquisition, is an important part of becoming a good healthcare professional (Kurtz, Silverman, Benson & Draper 2003). Although healthcare professionals may be proficient in one or more languages, they often experience problems with applying communication skills in medical practice (Kurtz et al. 2003). With appropriate teaching, effective communication skills, including a second or third language, could be acquired and retained (Aspergren 1999; Kurtz, Laidlaw, Makoul & Schnabl 1999; Makoul & Schofield 1999; Spencer & Silverman 2001).

The graduate attributes referred to above are useful as they provide a framework for developing effective communication between healthcare worker and patient, and place communication process skills within a comprehensive clinical context. The framework is designed to equip students to give structure to the consultation process and to build a relationship with the patient. Relationship building between patient and healthcare professional requires appropriate communication skills and patient involvement. The patient can only be involved if the healthcare professional is able to communicate in the language of the patient and when appropriate language skills are applied (Spencer & Silverman 2001). To be able to communicate in the language of the patients when they do not share a common language, students must acquire the essential language competencies and communication skills by participating in an effective language acquisition course.

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Theoretical frameworks play an important role in research and can be defined as the 'blueprint' or the guide for research (Grant & Osanloo 2014). For the purpose of this chapter, social justice theory was used as theoretical framework.

Healthcare professionals subconsciously accept and internalise attitudes, knowledge, beliefs and values of the institutional and organisational culture of medicine without knowing they are doing so (Eagleton & Bourdieu 1992). Healthcare professionals' practices, perceptions and attitudes are shaped by their interactions in specific contexts (Bourdieu 1991). Power is present in all interpersonal relationships; there is no interaction in which power is not relevant (Foucault 1982). In health care, professionals tend to be in a position of power as regards the patient. Hence there is an unequal relationship between healthcare professionals and patients, with healthcare professionals having legitimised, referent and expert power (Beisecker 1990). Patients are thus reliant on healthcare professionals to provide the care and services that they need (Bending 2015). In the context of this chapter, it is also important to keep in mind that power can be expressed through strategies such as language.

The social justice approach emphasises recognition, distribution, representation and belonging, and strives for 'participatory parity' where people from different backgrounds can participate in social life, including a healthcare context (Fraser 2009). Recognition refers to the way in which people are seen (Bozalek & Leibowitz 2012). Burke (2015) argues that "misrecognition operates at symbolic, cultural and emotional levels". Representation and belonging are concerned with those that are regarded as social members, those whose voices are heard, and those who have a right to support and care (Fraser 2009). Although a caring, respectful and empowering communicative health professional-patient context has proved to improve patient outcomes (Zolnieriek & DiMatteo 2009), there are real challenges with regard to the enactment of this kind of care due to the inherent power imbalance in the health professional-patient relationship.

BACKGROUND TO THE STUDY

Few language programmes effectively equip student-professionals with communicative skills in the context of their profession (Maseko 2007). Research has shown that students, and in turn, healthcare professionals, trained in South African institutions of higher learning are not able to cope in South Africa's multilingual and multicultural environment because they cannot effectively provide services to the majority of the people they are supposed to serve, that is, speakers of African

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languages (Maseko 2007; Maseko & Kaschula 2009). There is, however, a growing awareness of the need to develop and review curricula in accordance with the needs of multilingual communities (De Klerk 2002).

In 2012, the FMHS of Stellenbosch University embarked on an initiative to include an isiXhosa clinical communication course in undergraduate healthcare training programmes. The course has four components, i.e. listening and speaking skills, basic reading and writing skills, an e-learning platform and a cultural component. The listening and speaking skills are developed through a range of communicative-based language learning techniques and activities preparing students for interaction with patients. Although the primary focus is on communicating meaningfully and intelligibly, the reinforcement of students' speaking and listening skills is also supported by the inclusion of numerous reading and writing tasks. The e-learning component consists of text-to-speech and task-based activities and quizzes which are based on the content taught during contact sessions. The e-learning is designed to complement the contact sessions and not to replace them. The content of the isiXhosa course is specific to the needs of each of the respective undergraduate programmes. In this particular approach, the focus is on learning how to communicate in a clinical context in the target language, namely isiXhosa, in order to bridge the power gap and the language and cultural barriers between healthcare professionals and patients and, in turn, improve health care. In order to develop students' isiXhosa language proficiency, the classroom setting is communication-based where students could engage in 'real-life' situations. Due to the fact that a language cannot be taught in isolation of the cultural aspects, this was also incorporated in the course. The cultural component gives students insight into a range of cultural practices and values relevant to family, the community and society. More specifically, students learn about respect, politeness, relationships, language and cultural sensitivity, as well as the impact of culture and language on different language groups. The aim of the course is to provide innovative language and communication interventions for healthcare practitioners to improve patient quality of care, promote multilingualism amongst healthcare professionals, and facilitate change in the healthcare environment.

The language course for Human Nutrition (HN), Occupational Therapy (OT), and Speech-Language and Hearing Therapy (SPH) students not only entails specific content for the specific group of students, it also specifies the objectives and outcomes that form an integral part of the curriculum, as well as particular assessment procedures.

Different learning programmes can be developed to serve the different communicative needs of diverse groups of learners (Nunan 2003). Breen (1984) states that the objectives (communicating in the target language) of a curriculum and the means

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(classroom procedures that develop communication in the target language) start to emerge when communication is placed at the center of the language curriculum. Therefore, the curriculum implemented for HN, OT, and SPH students was designed to follow a communicative approach. Students thus have the opportunity to partake in activities such as group dialogues or engaging in text-to-speech activities on the e-learning platform. Also, when students are being assessed, they are required to do an oral with a simulated patient, instead of a written test. Students are therefore continuously compelled to speak the language, rather than focusing on writing skills.

The content of the isiXhosa clinical communication course is discipline specific, i.e. students acquire knowledge within their respective fields which they will be able to apply during consultations with patients/clients. During the first year of the isiXhosa course, students are first exposed to content regarding introductions (such as greetings and developing rapport) and case history before being exposed to discipline specific content. The content regarding introductions and case history are the same for all the undergraduate programmes during the first semester of the first year of students' enrolment in the isiXhosa course. From the second semester onwards, the content differs according to the respective undergraduate programmes. The following table provides an overview of the isiXhosa content taught in the respective undergraduate programmes.

TABLE 8.1 Overview of content of the isiXhosa clinical communication course in the respective undergraduate programmes

	Human Nutrition	Occupational Therapy	Speech Therapy
First year			
Second year	Develop rapport; Case history (accommodation, personal details, family background, employment, lifestyle habits); Directions in hospital setting; Systemic questioning and providing diet history	Develop rapport; Case history (accommodation, personal details, family background, employment, lifestyle habits); Directions in hospital setting; Weekly and weekend routines	Develop rapport; Case history (accommodation, personal details, family background, employment, lifestyle habits); Directions in hospital setting; Oral-sensory motor examination; Articulation screening; Hearing screening
Third year	Meal follow-up; Anthropometrical and clinical examination; Interviews on healthy and non-healthy food types	Weekly and weekend routines; Disability grants; Range of motion	Receptive diagnostic tests; Print awareness; Neuro-screening (language) assessment procedure
Fourth year			Neuro-screening (language) assessment procedures

Source: Compiled by the author from programme documentation

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This research study (Du Plessis 2017) was intended to explore students' experiences of the isiXhosa clinical communication course implemented at FMHS, specifically in the Speech-Language and Hearing Therapy, Occupational Therapy, Physiotherapy, and Human Nutrition programmes. The aim was also to investigate students' communicative competence after completion of this course.

THE STUDY

In the following section an outline is given of the research design, research methods and participants.

Research design

The study was an evaluation study of a single 'programme' (the isiXhosa clinical communication course). In this context, 'programme' refers to an intervention or set of activities with the aim of achieving external objectives (Rutman 1984). Programme evaluation "entails the use of scientific methods to measure the implementation and outcomes of programmes for decision-making purposes" (Rutman 1984:10). Rossi and Freeman (1993:5) define programme evaluation as "the systematic application of social research procedures for assessing the conceptualisation, design, implementation and utility of social intervention programmes". Programme evaluations are done in order to determine the worth and achievements of a specific programme, to provide explanations for the achievements, to improve programmes, and to generate knowledge (Kiely 2009; Patton 1997).

Four questions should be addressed during the process of evaluation, namely: 1) was the programme designed in such a way that the needs of the target group are being addressed; 2) was the programme well implemented and well managed; 3) did the programme meet the required outcomes; and 4) was the programme cost-efficient? (Posavac & Carey 1992).

This study focused specifically on the first three questions, i.e. the evaluation of need, the evaluation of process and the evaluation of outcome. Evaluation of efficiency was not included as the aim of the study was primarily to determine the effectiveness of the isiXhosa clinical communication course in terms of preparing students for communication in the clinical context.

Ethical clearance for the study was granted by the Health Research Ethics Committee and all participants gave informed consent to be part of the study.

CHAPTER 8 • COMMUNICATION IN MULTILINGUAL HEALTHCARE CONTEXTS**Research methods**

Qualitative data were gathered by means of individual interviews with the lecturers, observations of simulated clinical situations, and document analysis. Furthermore, both quantitative data and qualitative data were gathered by means of a student survey. This chapter focuses on the qualitative survey results that represent the student voice, and the clinical observations.

Participants

Two distinct populations were sampled in this research study. These two groups included students and lecturers involved in the isiXhosa clinical communication course.

Three groups of students were included, namely third-year Occupational Therapy (OT) students, third-year Human Nutrition (HN) students, and fourth-year Speech-Language and Hearing Therapy (SPH) students. Being in their final year, these students were well positioned to judge the effectiveness of the communication course as well as the extent to which they had been prepared to communicate effectively in the healthcare context.

RESULTS

The results are discussed in terms of the five communicator competencies of the CanMEDS framework. A distinction is made between the survey responses and the observations of the simulated clinical encounters.

Competency 1: Develop rapport, trust and ethical therapeutic relationships with patients**Survey responses**

Generally, students were convinced that they were able to develop a rapport with patients, i.e. students could introduce themselves and obtain biographical information. They felt competent in this regard as the course equipped them to gather background information and personal details in their communication with patients. Having the ability to communicate in the language of the patients made them feel respected and enabled them to “have access to people from other cultures, as well as language and communication”. One of the students indicated that “it helps to build trust if you speak to a patient in their own language” and “immediately patients tend to open up more and give better cooperation”.

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Students indicated that the course gave them the required knowledge and skills to ask detailed questions regarding personal particulars, family background, accommodation, employment and lifestyle habits which improved the communication between students and patients, and, in turn, helped in building a relationship with patients.

Even though most students felt that they were able to develop rapport and trust to a considerable extent, some students indicated that the programme only enabled them to acquire rudimentary vocabulary to communicate on a basic level, but they could not fluently communicate with patients in isiXhosa. Having only basic vocabulary became a problem as students were not always able to understand patients' questions or responses. From students' responses it is clear that they were highly dependent on what had been taught in class as they stated that they would not be able to understand if patients responded differently from what they had been taught. They were able to ask questions, but could not respond to patients' responses, because they were not always sure what the patient had responded. One student commented: "In real life patients often answers things that was not covered in class; then one cannot really understand."

Students further reported that even though they could develop a rapport with patients, they did not have sufficient vocabulary to have a general conversation to the extent that they could build therapeutic relationships. Students were of the opinion that a high level of comprehension was needed to understand the language in order to communicate effectively, and they were not confident that they had reached that level of comprehension yet. One of the students substantiated this by stating that they "only learnt direct answers and questions, and not how to understand the language".

Observations of the simulated patient encounters

During observations of students engaging in consultations, it was clear that students could effectively develop a rapport with the simulated patients. Students were able to establish a positive relationship by introducing themselves, explaining their student role, asking permission to ask the patient questions and ensuring them of the confidentiality of the information. Students also demonstrated socially appropriate behaviour by addressing patients properly and greeting them with a handshake. When patients indicated that they were not feeling well, students were able to empathise with them. By developing rapport and establishing a positive relationship, patient-centredness was partially demonstrated as respect was shown towards the patients.

It was, however, not fully demonstrated due to the fact that patient-centred communication must be enabled through shared decision-making which is essential for

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formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care. Students were unable to formulate diagnosis, deliver information, and facilitate a shared plan of care. Furthermore, students were not actively listening and paying attention to the responses of their patients; they were merely trying to get through the necessary questions, and, as a result, tended to respond incorrectly.

Competency 2: Accurately elicit and synthesise relevant information of patients and families

Survey responses

Generally, students did not feel confident that they could accurately elicit information from patients and their families. Even though students were able to elicit basic information relevant to the context, they would not be able to fully understand patients' responses if they were out of the ordinary or if their responses included vocabulary that students had not acquired. They indicated that a high level of comprehension was needed to enable them to elicit information; however, they had not reached that level of comprehension and thus did not feel "fluent enough to be able to get the relevant information".

Students also found that isiXhosa patients tended to speak very fast and pronounce words differently from how they were taught which made understanding patients' responses difficult. This left students unable to ask further questions in order to elicit the relevant information needed. One student commented that "it is difficult to get all the relevant information compared to if you were asking it in your home language" which sometimes caused "the depth and the extent of the information to be compromised".

However, even with limited vocabulary, it was still "an advantage being able to ask for information in the patient's language". Students were able to identify some of the words and would then try and construe meaning.

Observations of the simulated patient encounters

Having observed the students in their respective contexts, i.e. Human Nutrition students doing a clinical anthropometric examination, Occupational Therapy students doing an interview on disability grants, and Speech students doing a neuro-screening assessment, it was clear that students could elicit relevant information in context. Even though students sometimes struggled to formulate questions or pronounced words incorrectly, they were still able to gather relevant information about the health problem experienced. Although students could not necessarily ask

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all the questions needed to explore the health problem in more detail, they could gather enough information to understand the patients' problem.

It was evident that students were not always able to probe for more information. They were mostly limited to asking 'yes' or 'no' questions and this left no room for further explanations.

Competency 3: Accurately convey relevant information and explanations to patients

Survey responses

Again, students only had basic vocabulary in this regard. They were able to give basic information about a diagnosis; however, further expansion was not possible. Students were of the opinion that they could only convey information relevant to the contexts which they had been introduced to in class. This limited them as there were too many variations in real life situations. In order to cope in situations where they were unable to provide patients with explanations, they tried to make use of either pictures or gestures.

According to students, the communication course was mainly designed to teach them how to ask relevant questions, and for this reason students felt that they needed more vocabulary and training in this regard. It was not aimed at teaching them how to provide patients with information and explanations. A student confirmed this when she said that "we are not yet able to give explanations on conditions, but it is not within the scope of the course to teach us all the kinds of illnesses/interventions".

Students further mentioned that patients often gave answers that they did not understand. This created a language barrier between student and patient. They also found it difficult to try and explain a process or treatment plan in a language that they were still learning. In situations where students did try to provide an explanation, patients could not always understand them. When students did not have sufficient vocabulary, they would use a mixture of English and isiXhosa in order to try and get the information across.

Observations of the simulated patient encounters

In the observations of simulated patient encounters I did not observe students demonstrating the ability to deliver information to patients in an understandable way. Students were either questioning patients or giving instructions to patients. For example, during Occupational Therapy students' consultations about disability grants, they were mostly asking questions about physical abilities, criminal offences, accommodation, lifestyle habits, personal details, etc. On the other hand, Human

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Nutrition students mostly gave instructions while performing a clinical and anthropometric examination. There were no instances where students gave any kind of information to the patients involved.

Students did not have the ability to encourage discussions and patient participation in decision-making. There were no opportunities where students asked the patients how they felt about a certain problem experienced or whether they would like to come back for a follow-up appointment or rather be referred to someone else for further examination. The only thing that students would do was to provide a follow-up appointment date for the patient.

Competency 4: Develop a common understanding on issues, problems and plans with patients to develop a shared plan of care

Survey responses

Students found it difficult to develop a common understanding of issues and problems with patients in order to develop a shared plan of care. This was due to them experiencing a lack of sufficient vocabulary. One respondent advanced the view that “there was limited time to practice the language, and therefore did not acquire the ability to develop a common understanding”.

Even though students could provide a brief description of issues and problems experienced, they would need more knowledge, terminology and practice to be able to plan assessments and treatments. The communication course did not teach them how to develop a common understanding of patients’ problems and how to develop a shared plan of care. Not having the necessary terminology made it difficult when patients’ responses were not being understood. Furthermore, it was difficult to try and help patients understand their problem. One of the students commented: “I don’t know how to develop a plan of care in isiXhosa yet and my understanding of issues and problems are still underdeveloped”, and added: “I feel as though the level of isiXhosa we understand is not good enough”.

However, even with limited vocabulary, and by using the language skills learnt, students were able to interpret some of the information provided by patients. Understanding some of the language and trying to communicate in the language of the patients also helped to improve the trust of the patients, and thus patients would cooperate better in trying to help students understand them.

Observations of the simulated patient encounters

When observing students, I found that students could effectively explore problems experienced by patients during their consultations with patients and they were

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able to ask appropriate questions to their patients. For example, in order for Occupational Therapy students to assess patients' readiness to return to work after having a physical disability, they were able to ask a wide variety of questions regarding pain experienced and patients' physical ability to take care of themselves. Sometimes students struggled to formulate their questions correctly which made the communication process slower, but the gist of the questions came across and the patients were able to understand them within the context.

Students were also able to explain certain processes to patients. For example, as part of the assessment process during an interview regarding physical disability, Occupational Therapy students could effectively explain to patients how a follow-up procedure would work. They could explain to patients that they would need to make an appointment and return to be assessed for three days in order to determine their work readiness. However, this was observed to a lesser extent with Human Nutrition and Speech-Language and Hearing Therapy students who were more limited in their knowledge.

Students were not able to engage patients in shared decision-making regarding a plan of care. They could only go as far as to provide the patient with a follow-up appointment.

Competency 5: Convey effective oral and written information about a medical encounter

Survey responses

Students could make basic clinical notes such as the time and date of an appointment attended. However, they were not able to explain a diagnosis or convey information about a medical encounter due to limited vocabulary. Students preferred making use of a translator when having to provide written reports as their "written work (reports) will not be adequate in isiXhosa and it wouldn't feel ethical to do so".

Observations of the simulated patient encounters

Students did not get the opportunity to demonstrate the ability to convey effective oral and written information about a medical encounter or to present effective oral and written reports of clinical encounters. Therefore, it could not be determined through observation whether students had acquired this skill or not. It is important to remember that students were observed in simulation, and thus it might have been different should they have been observed in the hospital context.

DISCUSSION

In my discussion of the results of the investigation, specific attention is given to communication competency levels and limitations, and challenges experienced with communication in a clinical context.

Communication competency levels and limitations

In the communication course, students had been introduced to cultural aspects of the language, that is, cultural values relevant to patients, family and the community, more specifically ways of showing respect and being polite, understanding relationships, and understanding the impact of differences of culture and language. Therefore, students developed an understanding of the cultural differences between themselves and their patients and thus found it easier to establish positive relationships by demonstrating socially appropriate behaviour.

In the survey, students commented that they sometimes struggled to formulate their questions correctly. This made the communication process slower, but the students could communicate the essential information clearly and the patients were able to understand them within the context.

Even though students were not fully competent in the language, having some communicative competency gave them a degree of confidence when confronted with their patients. By trying to communicate in the patients' language, students won the trust of the patients and thus patients would cooperate more readily in trying to help students understand them.

On the downside, students found it difficult to elicit relevant information from patients, to convey relevant information and explanations, and to develop a common understanding of problems experienced. One of the core competencies of being able to convey relevant information to patients is the ability to retrieve patient-specific information from the data systems. The communication course did not equip students to meet this requirement.

Having only basic vocabulary was problematic as this limited students' ability to give information about a diagnosis and expand on it, or to explain a process or treatment plan. Students were mostly taught how to ask relevant questions, rather than how to provide patients with the necessary information and explanations, and thus students could not communicate all the important information to patients. In addition, students could also not develop a common understanding of issues and problems with patients in order to devise a shared plan of care. They found this difficult due to a lack of appropriate vocabulary. The inability to formulate a

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diagnosis, deliver information, create mutual understanding, and facilitate a shared plan of care resulted in poor patient-centred communication.

The skill of listening in learning a language is very important. By listening, vocabulary and understanding of implied meaning are expanded, and so, effectively learning a language depends, amongst other things, on how much one listens and integrates what has been learnt. It is one thing to learn a new language, but it is another to apply what has been learnt in practice. The ideal is to be prepared to practise speaking with patients confidently (Pfaff & Couper 2009).

Pfaff and Couper (2009) advance the view that second-language learning has moved away from the traditional focus on grammar and translation to communicative and task-based methods. The natural approach of Krashen (1983) complements Pfaff and Couper's view and suggests that language is acquired by hearing the language, and not by learning its formal grammatical rules. In this study students were mainly focused on getting the grammar and pronunciation right, rather than on speaking the language in an intelligible manner. When students conversed with patients, it seemed as if what was being said was merely 'parrot speak'. Once students couldn't remember what to ask or say next, the consultation could not proceed. This points to the challenges of using a second or third language to communicate in the healthcare context, but also to deficiencies in students' communication training.

Students felt that they were very dependent on what they had learnt in class. In every consultation, patients responded differently and this variety of responses was not covered in the course. Consequently, students were limited to certain contexts and thus restricted in terms of content, knowledge and vocabulary. Therefore, if patients responded differently to what had been taught in class, students were unable to understand them. When students did not understand, they were not always able to clarify what had been said and, in turn, a breakdown occurred in communication between student and patient. Since students had not acquired the skill of strategic competence, they did not know how to enhance the effectiveness of communication or repair and compensate for breakdowns in communication (Meenakshi 2015). Some students relied on key words only to get their message across. Sometimes, even though not always successfully, students would try to cope in these situations by making use of pictures or gestures. For example, there was one instance during an observation when a student could not recall how to say, "Sit down", and as coping mechanism, the student showed the patient by means of hand gestures to sit down.

Regardless of the challenges students faced, they remained positive. Once students were in the clinical context, they realised the practical use of the communication course and the value it added when in consultation with their patients.

CHAPTER 8 • COMMUNICATION IN MULTILINGUAL HEALTHCARE CONTEXTS**Challenges of communicating in a clinical context**

Even after completing the clinical communication course, students still found it challenging to speak the language fluently. Apart from the course being restricted in terms of vocabulary, students did not have enough time to practise and use the language. It would have been useful for students to be able to immerse themselves in the community where the target language is spoken or to have a tutor. It would also have been beneficial to integrate the communication course into students' clinical rounds, rather than treating it as a separate entity. Communication skills training is often done in isolation and not as part of the context in which it needs to be applied (Silverman 2009). There is thus a strong argument for providing a clinical learning environment which is suitable for communication skills training that focuses on discipline-specific communication skills (Conn, Lake, McColl, Bilszta & Woodward-Kron 2012).

The fact that students were only exposed to clinical content, and not general content as well, limited their understanding of patients' responses and their ability to build a relationship with patients.

From the results, the following specific challenges could be identified: teaching approach, simulation, patient-centredness, and a clinical learning environment.

The teaching approach in the isiXhosa clinical communication course has moved away from traditional teaching of grammatical structures and translation methods (Pfaff & Couper 2009). Instead of focusing mainly on grammar, the course is designed to adopt a communicative approach. This means that students participate more in communicative task-based activities which enable them to engage in 'real-life' situations. These task-based activities are supported by simulation which is integrated in the communication course. Students are provided with opportunities to engage with simulated patients who are trained according to a variety of contexts. Seeing that role-play is important for learning and mastering new communication skills (Johnson & Johnson 2000), simulation creates a powerful learning experience for students in a controlled learning environment (Kalaniti & Campbell 2015). Kolb's (1986) experiential learning theory supports learning in simulation as it emphasises the concept of 'learning by doing' with learning as a process of building on concrete experiences. By providing a bridge between theory and practice, simulation offers a suitable context in which clinical communication skills can be practised (Stoneham & Feltham 2009; Kurtz et al. 2005).

However, even though the focus is on communication and not specifically on the correct use of grammar, students still tend to memorise the content taught in class instead of understanding the language. Furthermore, students depend greatly on

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what they have learnt in class, rather than using the acquired language knowledge and trying to formulate their own sentences to communicate with their patients. As a result, communication broke down and language barriers occurred between students and patients.

Communication comprises more than merely vocabulary and language structures. It is about understanding cultural differences and building relationships by using appropriate communication skills. It is also about understanding a person, and thus focusing on patient-centred communication, and in turn, the importance of patient-centredness (Frank 2005). Even though students are aware of the cultural differences between different language groups, they still lack patient-centredness. Students are well trained in developing rapport and trust, but they lack knowledge required to formulate a diagnosis, deliver information, reach mutual understanding, and facilitate a shared plan of care. These aspects are important as patient-centred communication must be enabled through shared decision-making and effective dynamic interactions with patients (Frank 2005).

In the literature, a strong argument is made for having a clinical learning environment which is suitable for communication skills training (Conn et al. 2012). Yet, communication skills training is often done in isolation and not as part of the context in which it needs to be applied (Silverman 2009). It is not only necessary to create a clinical learning environment; more particularly, it is essential to focus on discipline-specific communication skills training (Conn et al. 2012). The isiXhosa clinical communication course is designed to be discipline-specific, that is, the content is specific to each of the respective undergraduate programmes involved. However, this course is taught in isolation and not as part of a clinical or practical module. The course will benefit students more in terms of exposure to the language and vocabulary if it could be integrated to be applied in a 'real-life' context, rather than in simulation. Students learn better if the acquisition of skills takes place within the context in which those skills are to be applied (Woolley & Jarvis 2007).

IMPLICATIONS FROM A SOCIAL JUSTICE THEORY PERSPECTIVE

In order to establish a more equal relationship and minimise the power gap between healthcare professional and patient, it is necessary for the parties concerned to be able to interact with one another. Equal relationships can only be established if patients are being recognised and therefore feel they 'belong'. In a clinical healthcare setting, recognition can occur through communication. Even though the students' vocabulary was limited, the mere fact that they were able to communicate in the language of their patients made the patients experience a sense of belonging.

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To some extent participatory parity was developed as students and patients from different cultural backgrounds were able to communicate, albeit in a rudimentary manner, in a common language. Students showed respect by being polite and forming relationships with patients as well as understanding the impact of the differences in cultures and languages.

Although in some instances a caring, respectful, and empowering communicative relationship between student and patient was created, there were still challenges regarding an inherent power imbalance. Patients rely on healthcare professionals to provide the care and services that they need, and so, if healthcare professionals are unable to communicate with their patients, these services cannot be delivered effectively. Students found it difficult to elicit relevant information from patients, to convey relevant information and explanations, and to develop a common understanding of problems experienced. Students were thus limited in their ability to give information about a diagnosis and expand on it, or to explain a process or treatment plan in the patient's language. This resulted in poor patient-centred communication, and, in turn, reinforced the power imbalance. It could also lead to patients eventually feeling misrecognised.

CONCLUSION

The development of an effective communication course in the health science context which will enable students to be fluent in the language of their patients remains a challenge. It might not always be possible to include all the vocabulary and content in the course materials regarding health problems students encounter. In terms of time and logistics, it might also not always be possible to integrate a communication course into an already existing medical curriculum.

However, the current isiXhosa clinical communication course implemented at the FMHS at Stellenbosch University has proved to be more effective than general language programmes with a focus on grammar, because it has provided students with discipline-specific knowledge. Even though students have not acquired all the vocabulary, knowledge and skill needed to communicate in a clinical context, the course has enabled them to communicate with patients to some extent. It has given students the confidence to approach isiXhosa-speaking patients and has provided them with the necessary skills to build relationships and to move towards patient-centredness. For an improved clinical communication course, continuous research and development work is essential.

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