

# Finding a voice: Supporting ESL nursing students' communication in clinical placement

*Report to:*

Ako Aotearoa: The National Centre for Tertiary Teaching Excellence, New Zealand

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## **Executive Summary**

This report outlines the key findings of a project that sought to identify the factors most likely to support effective communication in clinical placements for undergraduate nursing students in New Zealand for whom English is a second language (ESL students). The experiences of ESL students as they completed a clinical placement were examined and compared with those of the students' clinical lecturers and preceptors.

Data for the study were collected through semi-structured interviews with seven individual students before, during and after their final clinical placement. Semi-structured interviews were also held with preceptors, and a focus group was conducted with clinical lecturers. These interviews and the focus group were supplemented by paper-based exercises designed to focus and stimulate the discussion, and to collect data on students' level of confidence in communicating. Information from the interviews and exercises was coded and grouped to produce four major themes or factors influencing effective communication on placement. The findings from the study point to the importance of facilitating students' entry to the placement community of practice, and their access to its interactions. The four major factors identified acted either to support or inhibit students' participation in the placement community, and therefore influenced their learning, including mastery of effective communication skills.

The study identified two critical factors intrinsic to the student, and two factors that could be considered as extrinsic to the student. The first intrinsic factor was the student's proficiency with English language. Of particular importance was the student's ability to use the sophisticated sociopragmatic language skills that are integral to effective nursing, and that enable the development of therapeutic relationships with clients and working relationships with colleagues. The student's use of learning strategies, including the ability to adopt the proactive approach best suited to learning on placement, was the second intrinsic factor. Extrinsic factors likely to support the student's integration within the community

of practice were the quality of the preceptor and the tone of the placement environment. The preceptor's attitude to and training for the role were critical in either facilitating or blocking the student's entry to the interactions of the placement; of similar importance was the atmosphere of the placement environment, especially as it related to an inclusive or exclusive attitude towards the student.

The major outcomes of this project point to the critical importance of providing direct and specialised instruction for ESL nursing students in the communication required for placement, for example through a communication-for-placement programme that includes a focus on sociopragmatic aspects of English. Such a programme should be developed jointly by ESL specialists and nursing faculty. It is also important that ESL students are given appropriate and direct instruction and practice to enable them to develop the active learning styles most suitable for placement. Further implications focus on the necessity to ensure that preceptors are adequately trained for their role, and on identifying appropriate clinical placement environments for ESL students. The report concludes with a series of practical recommendations for undergraduate nursing programmes, and a proposed model of 'best practice' in supporting ESL students to develop effective communication skills for placement.

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# 1 Introduction

New Zealand is facing a critical shortage of qualified nurses. Nursing features on the Department of Labour's Long Term Skill Shortage List (Department of Labour, 2009), meaning there is a "sustained and ongoing shortage" of skilled nurses in New Zealand. It is estimated that between 19,000 and 27,000 extra health workers will be needed within the next decade or so (Boland, 2009).

At the same time, New Zealand is becoming increasingly culturally diverse. This diversity in population brings with it the need for a matching diversity in the healthcare workforce, so as to provide optimum levels of care for all our people. Encouraging students from a variety of cultural backgrounds to enrol in undergraduate nursing programmes and retaining these students through to successful completion and eventual registration as New Zealand nurses are therefore important factors in meeting the healthcare needs of our population.

However, students from other cultures face a variety of challenges while studying in New Zealand, especially if they have a first language other than English. Adapting to a different culture and its expectations of tertiary students and functioning effectively in the tertiary environment in a second language place heavy additional demands on these students. International research has shown that attrition rates for ESL nursing students tend to be higher than for their non-ESL counterparts (Alvarez & Abriam-Yago, 1993; Gardner, 2005).

As an academic advisor in a provincial polytechnic in the North Island of New Zealand, I work with staff from a wide range of disciplines. Over recent years, programmes within the School of Nursing at the polytechnic have experienced numbers of enrolments from ESL students. Concerns have arisen about these students' needs and experiences in the programme. These concerns often come to a head during the students' periods of clinical placement: blocks of time in the nursing workplace, where students work alongside designated registered nurses (preceptors) in everyday healthcare settings such as hospitals

or clinics, practising and developing nursing skills. While ESL students might, as expected, struggle to some extent with the academic demands of the programme in a second language, the placements bring a unique set of challenges that can prove overwhelming.

Learning the communication skills required of a health professional in New Zealand is an important part of the journey to effective integration in the New Zealand nursing workforce, but one that is particularly challenging when it has to be achieved in a second language. Difficulty in reaching an effective level of communication, due to inadequate English language proficiency, is often cited as the main obstacle to a successful placement outcome for ESL students. However, anecdotal evidence suggests that other factors, such as discrimination or cultural misunderstandings, might also play a significant part.

## **1.1 Nursing Training in New Zealand**

The Nursing Council of New Zealand is the statutory authority, delegated under the Health Practitioners Competence Assurance Act 2003, governing the practice of nurses in New Zealand. The Council sets and monitors standards for nursing practice to ensure “safe and competent care for the public of New Zealand” (NCNZ, 2005, p.1). These include standards for nursing programmes, standards for registration and standards for ongoing nursing competence.

The Nursing Council sets key competencies for each ‘scope’ of nursing practice: nurse practitioners, registered nurses, nurse assistants and enrolled nurses. Competency 3.3 of the ‘Competencies for registered nurses’ (NCNZ, 2007) relates directly to communication. This competency and its five associated indicators provide guidance on what might constitute ‘effective communication’ in the clinical setting.

### **Competency 3.3:**

Communicates effectively with clients and members of the health care team.

Indicator: Uses a variety of effective communication techniques.

Indicator: Employs appropriate language to context.

Indicator: Provides adequate time for discussion.

Indicator: Accesses an interpreter when appropriate.

Indicator: Discussions concerning clients are restricted to settings, learning situations and or relevant members of the health care team. (NCNZ, 2007, p. 17)

An analysis of the other key competencies and associated indicators reveals more about the types of communicative activities expected of competent registered nurses. A wide range of interpersonal communication, involving a range of registers and degrees of complexity, can be inferred (see Table 1.1). Being able to engage effectively in these communicative activities could be considered to represent competency in communication for registered nurses.

Clinical practice hours allow nursing students to put communication skills theory and training into practice. Undergraduate nursing programmes in New Zealand are required to provide a minimum of 1100 clinical practice hours for all students, which allow them to integrate theory with practical experience and attain the competencies required for registration (NCNZ, 2005). These hours are usually structured into blocks of several weeks (clinical placements) throughout the programme, culminating in a final block of six weeks at the end of the third year.

While on clinical placement, students work alongside professional nursing staff. A designated registered nurse within the placement is assigned as the student's preceptor, acting as 'buddy', mentor and role model, providing the student with daily feedback, and gradually handing over responsibility for patient care. Each student also has a designated clinical lecturer for the placement; this lecturer supports the student, provides overall supervision for the placement experience, and visits the student in the placement. While on placement, students are expected to display a proactive attitude, actively seeking and initiating clinical learning opportunities (NETS/NENZ, 2007). Clinical lecturers and preceptors provide feedback on each student's clinical performance, including interpersonal communication skills, to enable the student to review or improve

his or her practice as necessary. Summative assessment of the student's performance in placement is undertaken by the preceptors in consultation with



**Table 1.1: Interpersonal interactions, inferred from Competencies for the Registered Nurse Scope of Practice (NCNZ, 2007)**

<b>Interpersonal communication tasks for registered nurses:</b>	<b>Requires interaction with:</b>
<ul style="list-style-type: none"> <li>• Delegate work and activities</li> <li>• Direct, provide direction</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse assistants</li> <li>• Enrolled nurses</li> </ul>
<ul style="list-style-type: none"> <li>• Seek advice</li> <li>• Identify and report situations affecting client or staff members' health and safety</li> <li>• Seek assistance and knowledge</li> <li>• Seek and receive direction</li> </ul>	<ul style="list-style-type: none"> <li>• Senior nurse</li> </ul>
<ul style="list-style-type: none"> <li>• Consult as requested and approved by client</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural and other groups</li> </ul>
<ul style="list-style-type: none"> <li>• Provide appropriate information</li> <li>• Provide health education</li> <li>• Discuss ethical issues</li> <li>• Collaborate with</li> <li>• Reflect on client feedback</li> <li>• Check client's level of understanding of healthcare</li> <li>• Answer clients' questions</li> <li>• Initiate, maintain and conclude therapeutic interpersonal interactions</li> <li>• Use psychotherapeutic communication skills</li> <li>• Use effective interviewing and counselling skills</li> <li>• Demonstrate respect, empathy and</li> </ul>	<ul style="list-style-type: none"> <li>• Client</li> </ul>

<p>interest</p> <ul style="list-style-type: none"> <li>• Establish rapport and trust</li> </ul>	
<ul style="list-style-type: none"> <li>• Seek clarification</li> <li>• Collaborate with</li> <li>• Share knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• Healthcare team</li> </ul>

the clinical lecturers, and is based on progress towards the competencies for the registered nurse scope of practice.

## 1.2 The Research Topic

This project was designed to provide greater understanding of the factors operating within the clinical placement and their influence on ESL students' ability to communicate effectively. The aim was to use this understanding to help tertiary educators plan and deliver programmes that enable ESL nursing students to develop the skills required of effective health professionals within the New Zealand nursing workplace.

Questions used to guide the project included the following:

- Does mastery of the English language equate to successful communication in placement?
- Are there other factors which contribute to effective communication, in this New Zealand workplace?
- How can effective communication in this setting be defined?
- How can we, as educators, support ESL students to become confident and effective members of the New Zealand health-care profession?

## 2 Literature Review

### 2.1 Competent Communication in a Second Language

A variety of models of competent communication have been proposed by researchers. Hymes (1967, 1972) first coined the term 'communicative competence' to refer to the ability "to convey and interpret messages and to negotiate meanings interpersonally within specific contexts" (Brown, 2000, p. 246). Hymes' model is based on the premise that competent communication requires more than knowledge about language rules such as grammar, vocabulary and discourse features. It also involves knowledge about how to use language to achieve intended outcomes and in ways appropriate to the context.

In recent times, sociolinguists have proposed models of competent communication that emphasise the importance of social and contextual factors. These models provide a useful framework for exploring the factors involved in communicating effectively within the context of a clinical placement.

Canale and Swain (1980) defined communicative competence with reference to four essential components: grammatical competence, discourse competence, sociolinguistic competence and strategic competence. The first two of these components could be considered to cover knowledge about the rules or forms of language (the '*what*' of language), whereas sociolinguistic and strategic competence could be considered to cover knowledge about how to use language appropriately to convey the intended meaning in a particular situation (the '*how*' of language, or pragmatics). Bachman (1990) developed and modified this model to formulate a description of 'language competence' (see Figure 2.1).

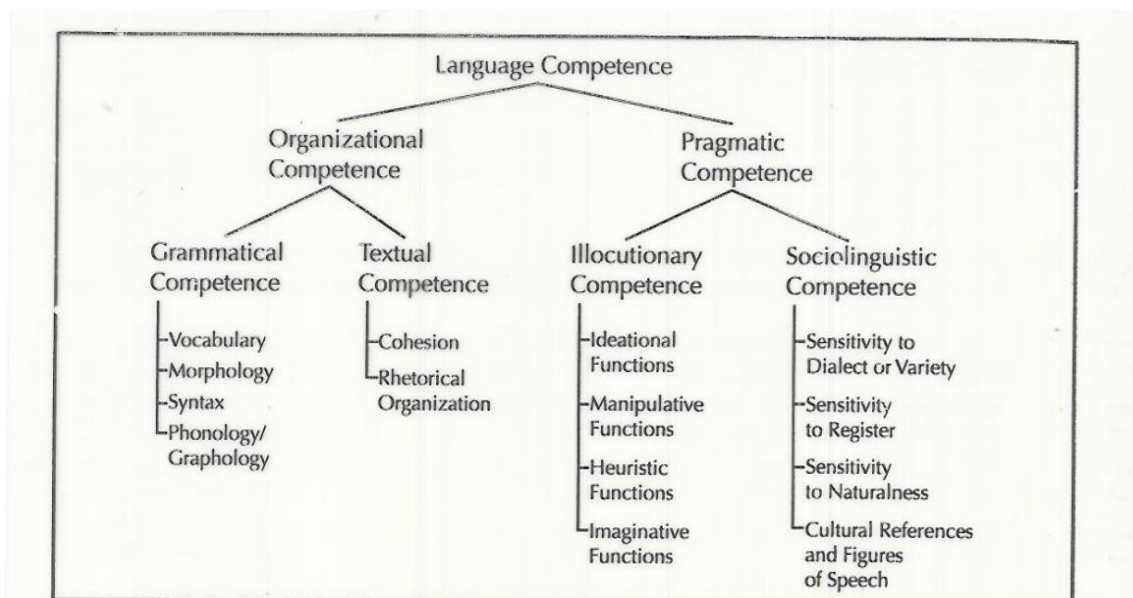


Figure 2.1: Bachman's (1990) model of language competence

Bachman's view of language competence comprises two main elements:

- **Organisational competence**, which is concerned with the formal features or rules of language (further divided into grammatical competence and textual competence, aligning with Canale and Swain's grammatical and discourse competence);
- **Pragmatic competence**, which is concerned with how language is used to achieve particular outcomes and in particular social contexts (further divided into illocutionary competence and sociolinguistic competence). Illocutionary competence is concerned with the ability to use language to achieve intended purposes, or 'functions': for example, to explain, to persuade, to apologise, to request. Understanding how to use language forms to achieve these functions in a given social context is a crucial aspect of second language learning (Brown, 2000). Sociolinguistic competence covers the ability to select an appropriate form of language to achieve the intended outcome with a particular person or people and in a particular context, and includes aspects such as level of formality, use of colloquialisms and cultural references, and ability to use language in a 'natural' manner.

According to Bachman's model, nursing students must not only have a proficient grasp of the rules of English, but must also develop pragmatic competence, an ability to use forms appropriate to a particular context and

purpose, in order to develop language competence. This language competence, combined with knowledge of the nursing context in New Zealand and assisted by a proficient use of language strategies, will enable students to communicate effectively in clinical placements.

Recent research on communication in the context of New Zealand workplaces has highlighted the importance of pragmatic language skills, in order for employees to 'fit in' and be viewed positively.

## **2.2 Pragmatic Language Skills in the Nursing Workplace**

Holmes (2005) investigated workplace language in New Zealand, analysing the social demands on employees in a range of workplaces, including those employing recent immigrants. Holmes' work emphasises the vital importance of small talk or social talk in 'oiling the wheels' of social interaction. In order to find acceptance in the workplace, workers need to understand what sort of small talk is appropriate and when it is appropriate; they also need to master acceptable ways of apologising, complimenting, criticising and complaining. For native speakers of English, this occurs naturally as part of their normal maturational and socialisation process. However, ESL speakers may find the norms around acceptable language use more problematic:

The sociolinguistic competence which underlies the ability to use talk in interaction successfully is typically acquired gradually over years of experience and exposure to language in different context. Those who move to a country where an unfamiliar language is used at work have not had this experience and exposure. (Holmes, 2005, p. 350)

We are often unaware of the underlying rules and conventions governing appropriate language use in our first language, and that these vary between cultures. For example, in the New Zealand nursing workplace it may be considered inappropriate to give an instruction by using an imperative form such as 'Raise your arm'. Those who speak English as a first language recognise intuitively that such a direct request is likely to be considered impolite (Holmes & Major, 2003). It is much more acceptable, in this context, to use a range of

softening and hedging devices to make the instruction less direct, for example, 'Could you just raise your arm for me, please'.

Native speakers are able to draw on their innate or intuitive knowledge of sociopragmatic conventions to adjust their speech in these linguistically complex ways, in order to suit the purpose and context. Second language learners, however, often lack knowledge of these pragmatic skills in the second language and are unaware that this can cause employers to feel that workers "seem unfriendly or uncomfortable at work" and that they do not "fit in smoothly" (Holmes, 2005, p. 346). As Holmes and Brown (1976) point out, this may be because second language learners have not had sufficient time, opportunity or direct instruction to enable them to develop sociolinguistic skills:

The second language learner, however, is further constrained by the limit of his knowledge of the language and will often therefore produce what he *can* say rather than what he *wants* or *ought* to say (Holmes & Brown, 1976, p. 430).

The profession of nursing demands an especially high level of sociolinguistic skills, as has been demonstrated by recent research.

As part of Victoria University's Language in the Workplace Project, Holmes and Major (2003) recorded and analysed the language used by nurses going about their daily work in a New Zealand hospital ward. Their findings provide valuable information about the nature and purpose of nurses' interactions. Nurses engaged in, on average, one interaction every three minutes, facing "unrelenting interpersonal demands" as they communicated with a wide range of people, including senior medical staff, colleagues, families, patients, social workers, cleaners, chaplains, and caretaking staff. The nurses used sophisticated sociolinguistic skills, expertly matching their language to the context and purpose of the exchange, in order to perform a wide number of communicative roles including "translator, mediator, counsellor, expert and advisor" (Holmes & Major, 2003, p. 5).

Holmes and Major also analysed the types of talk that the nurses engaged in, making a distinction between medical, transactional talk and non-medical or social talk. Contrary to what might be expected, the majority of the nurses' talk (about 60 per cent) was non-medical. This informal talk, including the use of

“strategically positioned small talk and amusing anecdotes” (p. 8) was balanced skilfully alongside medical talk to establish rapport and help patients feel comfortable in the medical environment and with medical procedures. Among the factors that characterised nurses’ effective communication with patients were skilful, sympathetic listening (for example, by providing encouraging, supportive minimal feedback), ‘softening’ of directives (for example, through use of hedging and modals), and use of humour. Holmes and Major conclude that “Nurses skilfully integrate responses to patients’ social needs with the requirements of their medical condition” (Holmes & Major, 2003, p. 5) and that sociolinguistic and sociopragmatic skills are important aspects of a nurse’s communication in the wards.

Fenwick, Barclay and Schmied (2001) explored nurses’ use of ‘chat’ or ‘social talk’ in neonatal nurseries. Through interviews with parents and nurses, and analysis of nurse-parent interactions, the authors found that a nurse’s use of language “was a powerful indicator of ... ability to provide facilitative nursing care” (p. 585). Nurses who were able to engage parents through skilful use of chatting were valued by parents and perceived as ‘good’ or competent. Through appropriate use of informal talk, including sharing of personal experiences, nurses were able to ‘get to know’ the parent and his or her needs, help the parent to feel confident and relaxed, and provide tailored care for the family.

The findings of this study align with those of a literature review on nurse-patient interaction, carried out by Shattell (2004). A key finding of this review was the importance that patients placed on the quality of their relationships with nurses. Referring to a study by Fosbinder (1994), Shattell describes how patients valued interpersonal interactions above other aspects of nursing care:

Patients wanted nurses to be genuine, not in a hurry, available and willing to talk to them. Patients wanted to be valued and respected as individuals and believed that social interaction was important. (p. 720)

Knowing how to interact appropriately with patients in order to establish these effective relationships requires skilful use of sociolinguistic strategies.

'Chatting', 'small talk' or 'social talk' is therefore an essential skill for nurses to master, for at least two main reasons. Firstly, it is a necessary part of establishing effective working relationships with nursing colleagues and other staff members. These friendly relationships enable nurses to be accepted by and fully integrated within the working team. Secondly, social talk is vital to the development of effective therapeutic relationships with patients, and is an expected part of the nurse-patient dynamic in New Zealand.

### **2.3 Learning Communication through Clinical Placements**

The clinical placement is, in effect, a workplace learning environment. In this workplace environment, learning occurs in a social context. Students learn through active participation in the workplace, and through working alongside more experienced others. For this learning to take place, students need to have access to the activities of the workplace, their experiences need to be structured, and they need to have "direct guidance from expert others" (Billett, 2001, p. 90).

#### **Communities of Practice**

Lave and Wenger (1991) first discussed the concept of communities of practice in relation to a theory of learning. They showed that learning is closely related to and influenced by the social situation in which it occurs. In a community of practice, members of the community learn from each other through participating in and sharing in a common context of real practice. Learning is therefore 'situated' in a particular context; it occurs through a process of "social co participation", where "Learning is an integral and inseparable aspect of social practice" (p. 31).

Newcomers to a particular community of practice become integrated with that community through a process of "legitimate peripheral participation" (Lave & Wenger, 1991, p. 14). In this model, the student's "partial, increasing, changing participation within a community" (p. 56) is acknowledged, accepted and validated. In this case, the peripheral participation is empowering for the



learner, enabling him or her to enter into and learn about the practices of the community and move towards greater participation over time. However, if the newcomer's participation is prevented or obstructed, the peripheral position can be disempowering.

Student nurses on clinical placements engage in this peripheral participation as they work alongside their preceptors and other nurses and gradually take on more responsibility for patient care. According to Lave and Wenger's model (1991), the student gradually gains competency in the practice of the nursing community, including its language and communication patterns, through actively engaging in that practice and through exposure to models of expert performance. This implies that the student must either be given access to the community, or be able to facilitate his or her own access in order to engage in its practice.

### **Second Language Learning in Clinical Placements**

In keeping with the idea of language learning as related to increasing participation in communities of practice (Lave and Wenger, 1991), Toohey and Norton (2003) completed qualitative studies of language learners in their social contexts. Their aim was to identify the factors in the learners' environments that enabled or hindered their access to the social networks and interactions within that environment, and thus their access to models of expert performance. In particular, they examined how the learners were able to help themselves gain access to these networks and interactions, by exerting personal influence or 'agency': that is, the ability to act upon and influence one's personal environment to further one's own cause. Agency is an important concept when exploring how learners in similar circumstances can experience different outcomes. For example, some students in Toohey and Norton's studies were able to exercise personal agency to overcome barriers to participation in a particular setting, whilst other learners were unable to do so.

According to these models, ESL student nurses in clinical placements will best learn the language required for successful communication when they are able

to participate actively in the community of practice, and when this interaction includes exposure to models of expert performance. For nursing students, then, an important consideration in their clinical placement is that they not only have structured opportunities to practise and develop competency in hands-on, practical tasks such as handling medications and operating monitoring equipment, but that they can also observe, and crucially are also invited to enter into, the full range of interactions that constitute nursing practice. It is also important that students are prepared to exercise personal agency so as to negotiate their own access to learning opportunities within the placement. It is possible that this preparation might include direct instruction in learning strategies that will support the proactive approach underlying the concept of personal agency.

## **2.4 Communication Problems**

ESL students in undergraduate nursing programmes may experience particular difficulties with communication in clinical placement (Jalili-Grenier, 1997; Boshier & Smalkoski, 2002; Abriam-Yago, Yoder & Kataoka-Yahiro, 1999; Guhde, 2003; Shakya & Horsfall, 2000). These difficulties include aspects of each of the categories outlined in Bachman's model of language competence: organisational, pragmatic and strategic competence. Specifically, difficulties may include use of medical terminology and abbreviations; pronunciation; comprehending and clarifying instructions; engaging in and maintaining small talk or casual social conversation with patients; assertiveness skills; paralinguistic features such as intonation, stress and volume of speech; and inappropriate body language, tone and manner (Hussin, 2009; San Miguel, Rogan, Kilstoff & Brown, 2006).

Inability to communicate fluently while on placement has been noted to cause high levels of anxiety for ESL nursing students (Campbell, 2008). As students withdraw from opportunities to use the target language, their language development is curtailed. Thus a cycle of inadequate performance is created, where language anxiety inhibits language development, thereby contributing to further anxiety.

The research reveals two types of programmes that may assist ESL nursing students to develop the communication skills required for clinical placements: ESL programmes on workplace communication in general, and ESL programmes focusing more specifically on communication for clinical placements.

## **2.5 Communication Programmes for ESL Students**

### **Workplace Communication Programmes**

Several authors have described workplace communication programmes for ESL students. Uvin (1996) described and contrasted two programmes designed to increase students' knowledge of workplace English. The first was based on a 'traditional' approach, using a needs analysis to determine the content, while the second was based on a participatory approach, with students helping to determine the content through a focus on real-life examples of problematic interactions. The second approach resulted in greater student engagement and gains in self-confidence and motivation, as well as improved language skills.

Riddiford and Joe (2005) also used students' own experiences and authentic data (recordings of workplace interactions from the Language in the Workplace Project, Victoria University of Wellington) in the development of a workplace communication programme for skilled migrants to New Zealand. The programme was divided into two six-week blocks. The first six weeks were designed to raise awareness of social pragmatic aspects of language, through analysing authentic data and engaging in role plays with native speakers. The following six weeks were spent in work placement, with a weekly classroom session that focussed on critical communication difficulties that students had experienced. Students examined these critical incidents, used them as the basis for further role plays, and discussed future actions. Although there was no formal evaluation of the outcomes of the programme in terms of increase in students' sociopragmatic language skills, students' feedback was that the use of authentic data had been "very useful" (p. 108).

Riddiford (2007) went on to investigate the effect of explicit instruction on the development of second language pragmatics, or the ability of learners "to

recognise and produce socially appropriate language in different contexts” (p. 88). The results clearly confirmed that explicit instruction, which involved students *noticing*, *understanding* and *practising* the language features, was more beneficial and effective in raising students’ ability with pragmatic features of language than implicit instruction.

### **Communication for Clinical Placements Programmes**

Two recent Australian initiatives have involved programmes designed specifically to support ESL nursing students in developing the communication skills necessary for clinical placements.

San Miguel et al. (2006) report on a 20-hour programme for first-year ESL nursing students, focusing on the oral communication skills required in clinical placement. Commercial teaching videos of nurse-patient interaction and role plays were used to develop students’ ability to engage in appropriate small talk with patients and to interact more effectively with staff. Results from the programme were reported as positive, with 12 of the 15 participants passing the subsequent placement. In their evaluations of the programme, students particularly valued the opportunity it provided to talk about communication issues in a safe and supportive environment. The authors of this report point to the need for ESL students to receive greater preparation on the culture and expectations of the clinical environment, and for clinical facilitators to receive specific training in working with ESL students.

Hussin (2009) describes the development of a programme that offered five levels of support for ESL students to facilitate their success in clinical placements. These levels of support consisted of professional development for faculty staff; workshops for students prior to and after clinical placements; individual student consultations for pronunciation practice; on-site supervision for ‘at risk’ third-year students; and web-based support materials.

The four-hour pre-placement workshop for students focused on communicating with patients and staff, and used role play to enable students to practise communication skills. As with the model outlined by San Miguel et al. (2006), structured formats for standard interactions were introduced and formed the

basis for practice. A second workshop, held after the clinical placement, offered an opportunity to work through students' own experiences of problematic interactions. Results of these workshops were positive, with all students successfully completing the practicum. Web-based learning support materials were also developed, incorporating material from the workshops as well as language exercises. Subsequently, and with larger numbers of ESL students within the programme, these workshops were replaced by a ten-week programme that included an hour a week of vocational English, focusing on listening and speaking in the nursing context. This content was eventually streamlined and delivered as a two-day intensive programme.

A further outcome of this project was the development of two sets of suggestions for improving clinical placements: one for clinical supervisors, '18 Ways to Enhance the Clinical Learning Experience of ESL Nursing Students' (Hussin, 2009, p. 380); and one for nursing students: '15 Hot Tips for Your Clinical Placement' (Hussin, 2009, p. 382).

## **2.6 Summary**

The literature shows that competent communication in clinical placement requires a sophisticated use of language, as students interact with a wide range of people for a wide range of purposes. Pragmatic skills such as illocutionary competence and sociolinguistic competence are important factors in nursing interactions, but research has shown that ESL students may experience difficulty with these aspects of language competence. Active participation in the placement and its interactions will expose students to models of expert performance and allow them to develop and practise appropriate communication skills. However, research suggests it is likely that ESL students will also need direct and explicit language instruction, especially in aspects of pragmatic competence, in order to develop the level of communicative ability required of a registered nurse.

This research project was designed to provide further information on the factors likely to lead to successful communication for ESL students on clinical

placement. Authentic data from a range of students completing a placement would be used to build a detailed picture of factors affecting student outcomes and whether these factors are, as the literature suggests, associated with facilitated access to the interactions of the placement and ability with sociolinguistic and pragmatic norms of New Zealand English.

Two key research questions were used to guide the study:

- What factors are critical to the success of ESL undergraduate nursing students in clinical placements, particularly in terms of effective communication?
- How can this information be used to inform teaching practices within nursing programmes, so as to improve outcomes for ESL students?

### 3 Methodology

Communication is a complex, interactive, personal and social activity, influenced by many factors. In order to begin to understand and interpret the factors influencing communication in clinical practice, it would be necessary “to delve deep into the subjective qualities that govern behaviour” (Holliday, 2007, p. 7). According to Creswell (2007):

We ... conduct qualitative research because we need a *complex*, detailed understanding of the issue. This detail can only be established by talking directly with people ... and allowing them to tell the stories unencumbered by what we expect to find or what we have read in the literature. (p. 40)

Talking directly and in depth to those involved in clinical placements would provide insights into their experiences and subjective understandings. From these discussions, themes and patterns would emerge (Holliday, 2007).

Data was collected from the three main groups involved in placements - students, clinical lecturing staff, and preceptors. This enabled the development of a complex picture of the clinical placement experience, and comparison of different groups' perceptions. Whilst it would also have been useful to discuss the experiences of the clients or patients, and to carry out direct observation of students 'in the field', the ethical implications, and the length of time needed to obtain the necessary approvals, precluded this.

Students were tracked as they moved through a clinical placement, by interviewing them as they prepared for the placement, while they were on the placement, and at the completion of the placement. These interviews were supplemented by a weekly email exchange.

Interviews were also held with preceptors, and clinical lecturers who had worked with ESL students were invited to attend a focus group.

Discussions with nursing faculty confirmed that the final placement in the programme (the 'Transition to Practice' placement) would provide a suitable focus for the research. This six-week placement occurs towards the end of the third year of the programme, and is the student's final clinical experience before sitting the external State Final examinations. At this point in the programme, the student would have a wealth of experience of clinical placements, and would be able to reflect back on previous placements as well as on the current placement. The timing of this placement fitted well with my own commitments, and would enable me to do initial background research and develop research instruments well in advance.

In considering the ethical issues associated with the research, it was necessary to evaluate the cost/benefit ratio (Cohen, Manion & Morrison, 2007, p.50). The potential for harm for those participating was considered to be minimal. Confidentiality would be maintained and my experience in working with ESL students would enable the provision of a supportive environment during the interview process. Moreover, it was possible that the students would appreciate the opportunity to discuss their experiences in an impartial situation with an attentive listener. On this basis, the research outline was put forward for peer review, and was subsequently judged to be of 'low risk'. Approval to carry out the project was received from the polytechnic's Research Committee. All data was collected from July to October, 2008.

### **3.1 The Research Process: Students**

All students about to complete their Transition to Practice placement were given information about the research study. This information included clear criteria for participation and a consent form.

Students meeting the following criteria were invited to participate in the research project:

- First language other than English
- Commencing Transition to Practice placement in August 2008
- Born in a country other than New Zealand



- Speak a language other than English with family

Seven students offered to participate, and agreed to be interviewed three times during the placement, for the interviews to be recorded, and for the data to be used in this report.

The students' backgrounds and general characteristics are summarised in Table 3.1 below. Each student is referred to throughout this study by a pseudonym. Students were offered the opportunity to nominate their own pseudonym if they wished. In addition, all students have been referred to as female. This was necessary to protect students' identities.

### **Student Interviews**

Interviewing began in August 2008 and continued until October 2008. Each student was interviewed individually three times: before placement, during placement and after placement. The interviews were semi-structured. This format allowed students to explore issues of personal importance, while still ensuring that key themes were covered. In this respect, the interviews aligned with Kvale's description of a semi-structured life-world interview: "neither an open everyday conversation nor a closed questionnaire" (2007, p. 11). A guide for each interview can be found in Appendix 7.1.

#### ***Student interview one***

The first interview had three main sections:

- General introduction and explanation of the project, and questions designed to gather background information about each student.
- Questions around clinical placements, including the student's attitude to the forthcoming placement and perceptions about communicating during the placement. Two exercises were used to stimulate discussion.

- **How do you feel about communicating?**

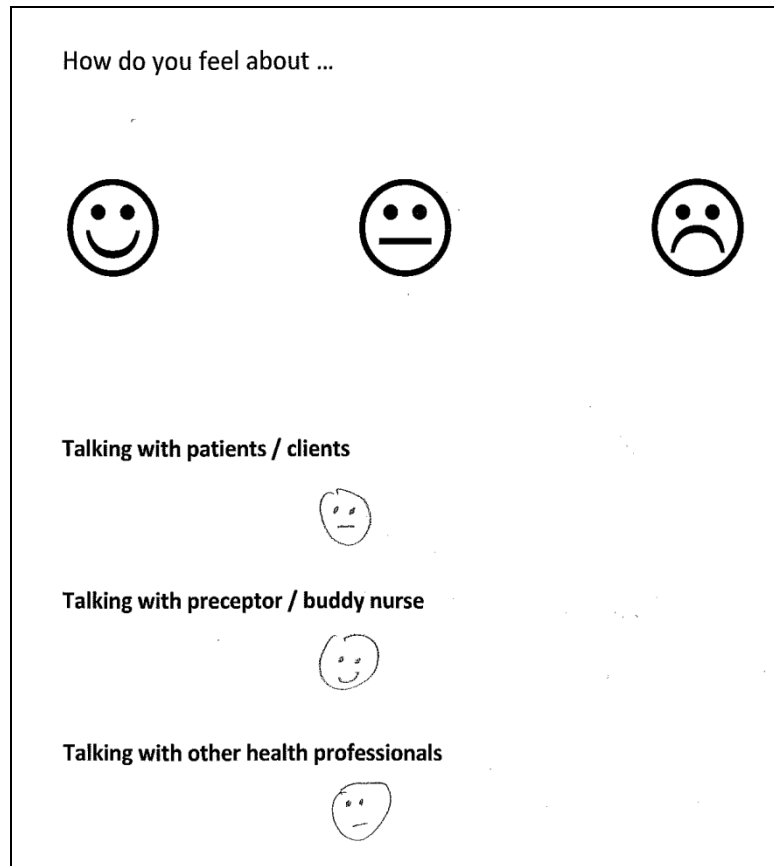
This was a simple rating exercise, where students indicated their level of confidence in communicating with the various groups on placement: patients, preceptor and other health professionals.

Students repeated this exercise at each interview (see Figure 3.2).

**Table 3.1: Background and characteristics of the students**

<b>Student</b>	<b>Age</b>	<b>Region of Origin</b>	<b>Time in NZ</b>	<b>Previous education</b>	<b>Healthcare Experience</b>
Sylvia	25	East Asia	5 – 7 years	<ul style="list-style-type: none"> <li>• High school in home country</li> <li>• Two years high school in NZ</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Bobbi	30	East Asia	4 ½ years	<ul style="list-style-type: none"> <li>• High school in home country</li> <li>• 15 months English language study in New Zealand</li> </ul>	<ul style="list-style-type: none"> <li>• Registered nurse in China, with five years' experience.</li> <li>• Part-time work while studying, in rest home.</li> </ul>
Jo	32	East Asia	2 ½ years	<ul style="list-style-type: none"> <li>• High school in home country</li> <li>• One year English language study in Australia</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
Tina	27	East Asia	5 years	<ul style="list-style-type: none"> <li>• High school in home country</li> <li>• Six months language study in NZ.</li> <li>• One year previous tertiary study in NZ (Bachelor of Health Science)</li> </ul>	<ul style="list-style-type: none"> <li>• Part-time work in a rest home before studying.</li> </ul>
Rose	27	East Asia	6 years	<ul style="list-style-type: none"> <li>• High school in home country</li> <li>• One year language study in Wellington. One year previous tertiary study in NZ</li> </ul>	<ul style="list-style-type: none"> <li>• Caregiver for those with intellectual disabilities.</li> </ul>
Sharon	33	Pacific Islands	4 years	<ul style="list-style-type: none"> <li>• High school in home country</li> </ul>	<ul style="list-style-type: none"> <li>• Caregiver in rest home – one year before enrolling in BN, and during first year of study.</li> </ul>

Joey	30	Pacific Islands	7 ½ years	<ul style="list-style-type: none"><li>• High school in home country</li><li>• Communication studies in New Zealand</li></ul>	<ul style="list-style-type: none"><li>• Part time caregiver, in rest home / hospital.</li></ul>
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**Figure 3.2: Example of completed confidence in communicating exercise**

- **Aspects of spoken language use**

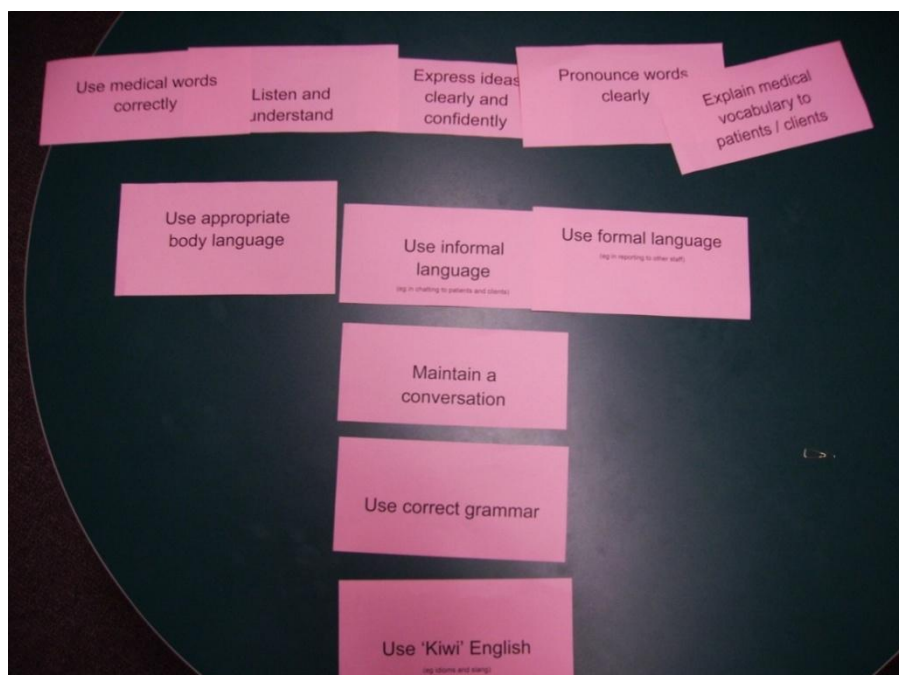
The second was a ranking exercise, based on models of communicative competence (for example Canale and Swain, 1980; Bachman, 1990). Students were given cards on which were written aspects of language that roughly correlated to the main components of communicative competence (see Table 3.3). These were not intended to be a comprehensive list, nor to be a detailed representation of each component of communicative competence. Rather, they were designed to stimulate discussion and reveal perceptions about language use in clinical placement.

Students were then asked to order the cards in order of importance. The cards were left in position and photographed at the end of the interview, for later analysis (see Figure 3.4). This exercise was repeated during the students' final interviews, so that any changes in

perceptions could be noted. Preceptors and clinical lecturers were also asked to complete this exercise during focus groups and interviews.

**Table 3.3: Aspects of spoken language exercise**

Component of Communicative Competence	Aspect of spoken language use
Grammatical competence	<ul style="list-style-type: none"> <li>• Use correct grammar</li> <li>• Pronounce words clearly</li> <li>• Use medical words correctly</li> </ul>
Discourse competence	<ul style="list-style-type: none"> <li>• Express ideas clearly and confidently</li> <li>• Listen and understand</li> </ul>
Sociolinguistic competence	<ul style="list-style-type: none"> <li>• Use formal language</li> <li>• Use informal language</li> <li>• Use 'Kiwī' English</li> <li>• Explain medical vocabulary to patients</li> </ul>
Strategic competence	<ul style="list-style-type: none"> <li>• Use appropriate body language</li> <li>• Maintain a conversation</li> </ul>



**Figure 3.4: Example of 'aspects of spoken language' exercise**

In response to the final question in the interview, 'Is there anything else you'd like to tell me about placements?' students often talked freely about their experiences, ideas for programme change, and ways in which ESL students could be supported. The initial interviews ranged from 40 minutes to an hour and a half.

### ***Student interview two***

The second interviews were held during week four of each student's placement. Students were encouraged to discuss their ongoing experiences of placement and how these matched their expectations, and to elaborate on what was going well and what was proving challenging. These interviews were shorter than the initial interviews, lasting between 20 and 40 minutes.

### ***Student interview three***

The final interviews were held during the week following completion of the placement. During this interview, students reflected on their placement and on their future plans, and were asked for their thoughts on how ESL students could be prepared for and supported during placements. These final interviews varied in length from around 25 minutes to over an hour.

### **Emails on Placement**

I had asked students if they would email me each week with news of their placement: something that had gone well and something that had been difficult. Although some students did email me, communication was sporadic. During face-to-face interviews, students remarked that they were too tired when coming in from clinical practice to compose the email, which of course needed to be in English. After some experimentation, I found the most effective communication medium between interviews was text messaging, and this was subsequently used to arrange interviews and to provide me with news of significant happenings such as job offers.

### **3.2 The Research Process: Clinical Lecturers**

A focus group seemed the best way of bringing this group together and of stimulating discussion around key issues. Focus groups allow participants to “develop and discuss ideas together, share their experiences and both agree and disagree” (Andrews et al., 2006, p. 864). In this way, a variety of key issues and perspectives would emerge.

An invitation to attend the focus group was sent to all clinical lecturers, with an information sheet and consent form. Five lecturers accepted the invitation, and key questions were circulated to them to allow time for reflection in advance (see Appendix 7.2). Each participant gave informed consent for the group’s interactions to be recorded, transcribed, and used in the report.

### **3.3 The Research Process: Preceptors**

The majority of the students were undertaking placement at a local hospital. Permission to contact their preceptors and conduct interviews was obtained from the Nurse Manager, Nursing Practice Development. Information about the study and an invitation to participate was forwarded to the relevant charge nurses, who passed this on to the preceptors.

Interviews with all preceptors were planned for the end of the placement. However, during the course of an interview, one student expressed reservations about the planned interview with her preceptor. While all other students were willing for me to talk to their preceptors, it was necessary to protect the anonymity and confidentiality of this student. Two of the remaining preceptors were invited at random to be representative of this group, and both agreed to participate. The topic guide for the preceptor interviews is provided in Appendix 7.3.

Figure 3.5 below shows the data collection timeline as a whole.



### **3.4 Data Analysis**

The interviews, focus group, emails and texts provided a wealth of rich data, which was transcribed and analysed in response to the first research question: 'What are the factors that facilitate effective communication in clinical placement, for English as a second language students?'

Following each round of student interviews, the recordings were transcribed verbatim, and participants were invited to check the transcripts for accuracy. According to Johnson (1992, p. 90), data should be analysed to identify "meaningful themes, issues, or variables, to discover how these are patterned, and to attempt to explain the patterns and relationships." Charmaz (2006, p. 42), in her description of grounded theory, advocates starting with a line-by-line analysis of the data to inform initial coding, and from there moving to focused coding. I therefore began the data analysis by working through each transcript, sorting and coding segments to identify significant categories of experience. Each student's transcript was then compared with others in the same round of interviews, to identify consistent codes across students. Finally, codes for each round of interviews were compared to confirm the major themes.

Transcripts of the preceptor interviews and of the clinical lecturer focus group were also coded for significant themes and compared with the student interviews. The themes were then distilled further, into four main factors affecting student communication on placement.

Each student's interviews were also read as a whole, to provide a picture of that student's complete placement experience or 'journey'. The interviews were also compared with the 'How do you feel about communicating?' exercise, in order to plot growth or decline in confidence against critical incidents in the placement.



### Weeks of Transition to Practice Placement

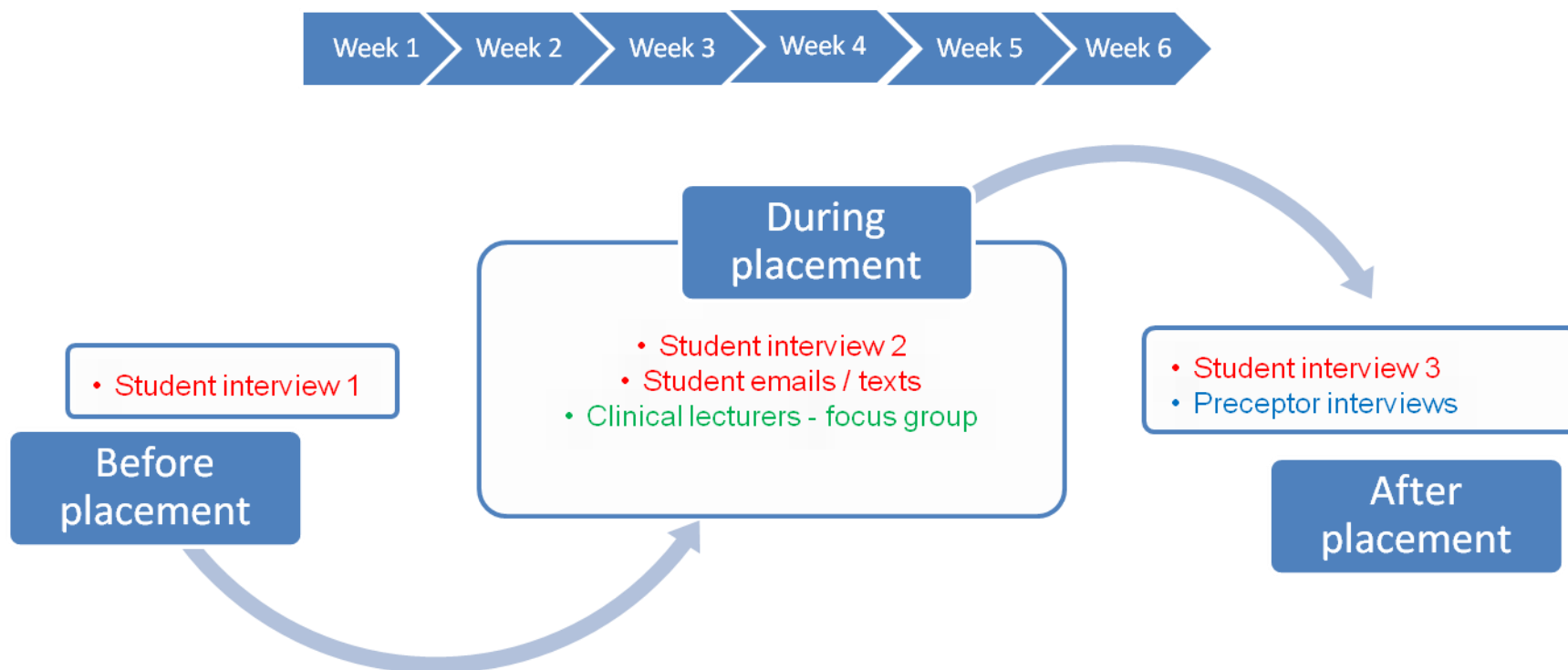


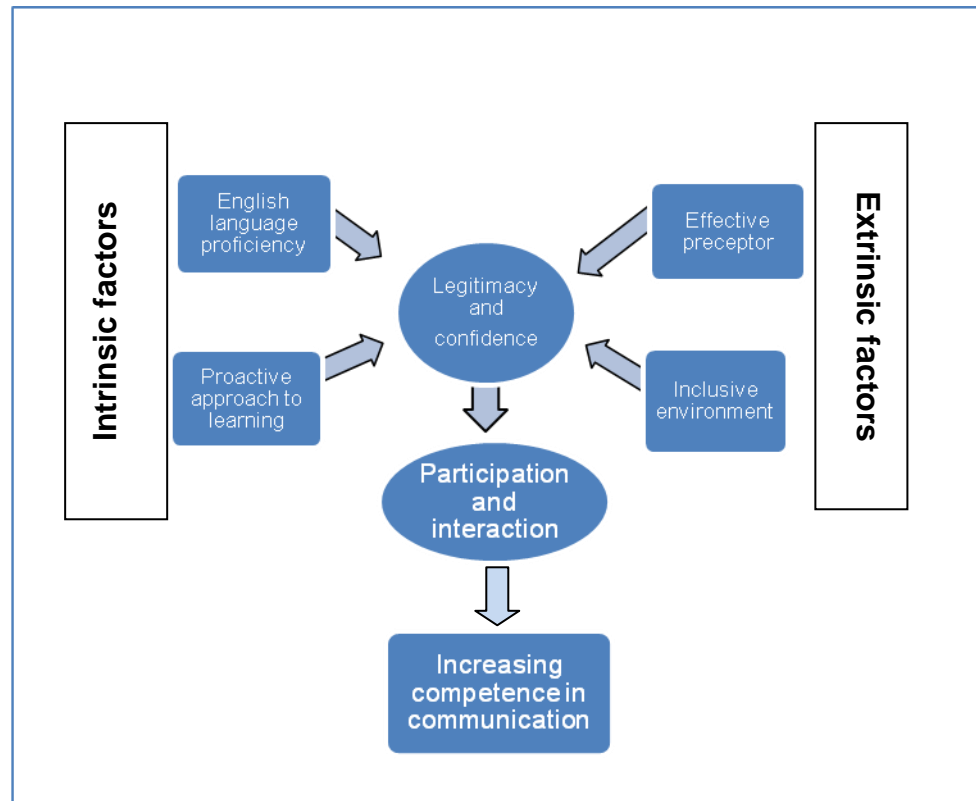
Figure 3.5: The data collection timeline

## 4 Key Findings

This section will discuss and interpret the main findings on the research questions. These questions relate to the factors that are critical to successful communication in clinical placement for ESL students, and the implications for undergraduate nursing education in New Zealand.

Underlying the factors affecting communication was the role of legitimacy within the placement community and how this supported students' confidence. In order to practise communication skills and become familiar with and proficient in the language appropriate to the placement, students required access to the interactions of the placement community, from a position of legitimate peripheral participation (Lave & Wenger, 1991). From this secure position, students were able gradually to master the language and communication patterns integral to the community of practice, and move towards full participation and competence. The extent to which students were confident to attempt this engagement was affected by a range of factors (see Figure 4.1). These factors could work positively to support a student's position of legitimacy within the community of practice, and thus enhance their confidence, facilitate integration and promote learning. However, the factors could also work to marginalise a student from the community, leading to loss of confidence, exclusion from the interactions of the practice and thus a negative effect on learning.

Some of the factors were intrinsic to the student and could be viewed as within the student's control, for example overall proficiency with English and ability to use a proactive approach to facilitate learning. Other factors were extrinsic, relating to the placement environment itself, and largely outside the student's control. These extrinsic factors contributed to the 'tone' of the placement environment, and included the level of support provided by colleagues and the effectiveness of the preceptor assigned to the student. Sections 4.1 – 4.4 below describe each of these factors in more detail, supported by examples from the data. Section 4.5 then provides a summary of this section.



**Figure 4.1: Factors influencing the development of competent communication on placement**

Where extracts from the student transcripts have been quoted, the student's words have been included verbatim. Errors in English have not been corrected. The source of each quote is indicated in brackets, with the student's pseudonym followed by a number denoting first, second or third interview. Information from the focus group of clinical lecturers is denoted by (CL) and from individual lecturers by (L1), (L2), (L3) etc. Information from interviews with the two preceptors is denoted by (P1) or (P2).

#### **4.1 Intrinsic Factors: English Language Proficiency**

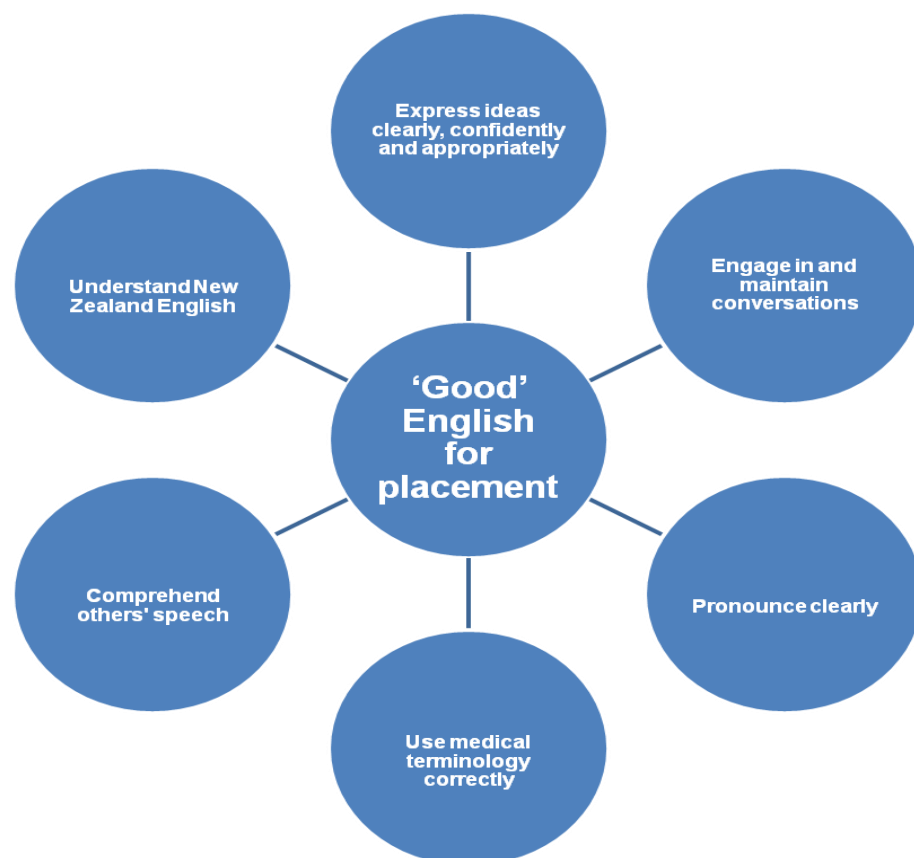
Students' proficiency in English was the principal factor identified as critical to successful communication in clinical placement. Students, preceptors and clinical lecturers were clear that students need to have 'good' English language skills to cope with the demands of the placement. Some students believed this was the deciding factor in whether they would pass or fail:

If you have good English, you can easily to manage the placement. If you ... have little bit difficulty with English conversation, that's a big challenge. Probably, I mean, you can't survive in the ward. (Tina 1)

The 'aspects of spoken language' exercise, which was completed by all participants, provided useful information on how they perceived 'good' English for placement. Information from this exercise, combined with and modified by data from the interviews and focus groups, suggests that the most important aspects of language use for placement include the following:

- The ability to express ideas clearly, confidently and appropriately
- The ability to comprehend others' speech
- The ability to understand Kiwi (New Zealand) English
- The ability to engage in and maintain conversations
- The ability to pronounce clearly
- The ability to use medical terminology correctly

Figure 4.2 below is a pictorial representation of these findings.



**Figure 4.2: Elements of 'good' English for communication in placement**

These aspects of English are, of course, inextricably intertwined: for example, to express themselves clearly and confidently within the placement, students also needed to use medical terminology correctly, and have clear pronunciation. With regards to 'Kiwi' English, all groups made a distinction between *comprehending* 'Kiwi' English and *using* it. Although students did not need to use 'Kiwi' English themselves, it was essential that they understood it, including idiomatic speech, humour and slang, especially when used by patients.

The data on each of these important aspects of English for placement, including problems and challenges experienced by students, are summarised below.

### **Express Ideas Clearly, Confidently and Appropriately**

As they progressed through their placement, all students experienced some problems with their spoken communication and most struggled at times to express themselves in a second language. They worried that their lack of fluency might lead others to view them negatively. When they received a negative reaction, or if others could not understand them, their confidence was set back:

If I say something they can't understand, I explain again. If they can't understand then, I just, "Oh my god, no." My confident will drop. (Ruby 3)

This drop in confidence then became a barrier to further attempts at interaction, and students might withdraw from situations that required spoken communication, thus excluding themselves from the practices of the community. The effect that this loss of confidence could have on decisions about placement and how to participate in it can be illustrated by the case of Jo. Previous experience had taught Jo that some people wouldn't understand her. Some had openly questioned why her spoken English was not more fluent after three years of study in New Zealand. As a result, she avoided situations where she would have to speak, such as answering the telephone on the ward. Indeed, her choice of theatre for the transition to practice placement was based on the premise that this context would not require much spoken English. Withdrawal such as this could result in students being viewed by their colleagues as passive, shy or unable to communicate, thus posing a challenge to their legitimacy within the community of practice.

Some factors that affected students' ability to express themselves appropriately were lack of automaticity in English, difficulties with the pragmatic rules of English, and interference from a first language. These difficulties were compounded when students became tired or were under stress. Mid-way through the placement, long shifts began to take their toll on Bobbi's communication:

I found it is very hard for me to organise an effective communication once I feel tired. My English channel just shut down in my mind, only Chinese channel still on. (Bobbi, email 26 September)

In tiring or stressful situations, students' ability to communicate could therefore drop, leading to loss of confidence and reluctance to participate in further interactions.

It was evident that some students lacked the pragmatic skills needed to 'soften' instructions, and that as a result they were perceived as 'bossy' or abrupt. Clinical lecturers identified this as a problem and felt that it was particularly noticeable when the student was under pressure:

They go back ... to the person and say, 'You've GOT to do this', 'cos she feels the pressure and hasn't got the skills to translate it in a nicer way of saying 'This is how we're going to run your day, and this is what's going to happen'. It's 'You MUST do this'. So it's often translated in a dominant fashion ... which is then seen as threatening. (CL)

The students themselves were aware that they sometimes came across as abrupt or rude, and were frustrated that they did not have the language skills to formulate requests appropriately.

As mentioned previously, inadequate knowledge of the sociopragmatic rules underlying appropriate language use could cause problems in communication. For example, a simple statement such as 'Mr. Brown looks uncomfortable' may be intended by the preceptor as an instruction for the student to give Mr. Brown some attention. This meaning is conveyed through subtle means such as tone of voice or patterns of intonation and word stress. If the student does not interpret the intended meaning correctly, for example by accepting it as a simple statement of fact, a breakdown in communication will occur and the student is



likely to be perceived negatively. Knowledge of the patterns of intonation and word and sentence stress of the second language (suprasegmental features of language) is therefore important to effective communication in a second language.

This was exemplified by a breakdown of communication experienced by Tina. Tina attempted to clarify the meaning of a medical term with her preceptor. The preceptor, however, interpreted the loud volume of Tina's voice as argumentative. Tina's perception was that this misunderstanding was due to transference of pragmatic patterns from her first language:

Sometimes you know when Chinese people speak Chinese, the tone we use really loud, but sounds for my preceptor is like I was arguing. Actually, I was going to discuss with her, not arguing. The tone, I mean from your first language, probably I've got that. When I speak English I need to be quiet, lower my tone. (Tina 5)

Whilst Tina felt she needed to modify the volume of her voice and speak more quietly, other students were perceived by their colleagues and lecturers as speaking too softly. This was interpreted as a sign that the students were shy or unassertive, which carried a negative connotation and thus presented a challenge to the student's legitimacy within the placement. Choosing the right volume and tone for each interaction is exceedingly complex and demands a deep knowledge of sociopragmatic rules of a language.

### **Engage In and Maintain Conversations**

In order to participate in the practice community, students needed to engage with a wide range of people. Taking part in both formal and informal conversations, for both transactional and interpersonal purposes, was an integral part of forging effective working relationships with both staff and clients. Formal, transactional communication, dealing with medical matters, could be problematic for students. Problems with formal conversations centred on correct use and pronunciation of medical terminology, considered below.

Problems with social conversations or 'chatting' were a recurrent theme. These problems included differing perceptions on the importance of chat in the nursing

workplace, finding suitable or shared topics of conversation, and understanding Kiwi colloquialisms, idiomatic speech and humour.

The ability to form relationships with patients through skilful use of social chat has been linked with effective nursing (Fenwick, Barclay & Schmied, 2001). This use of social talk is an expected part of the nurse's role in New Zealand, but could be problematic for ESL students from a cultural background with a different view of the nurse's role:

And one of the things that for ESL students, is that nurses need to chat, to patients, it's what I call the 'nurses' chat', and a lot of them, culturally, that's not appropriate and also it's something they don't have confidence with. (CL)

Even when students did understand the importance of engaging in social chat, it proved difficult for the reasons above.

### **Pronounce Clearly**

Pronunciation was a problem for the majority of the students in the study. Colleagues, patients and preceptors found it difficult to understand the students' speech at times, and students often had to repeat words. These sorts of difficulties could challenge the student's developing sense of identity as a member of the community of practice, and their willingness to initiate the communication that would lead to language growth.

First language interference, leading to difficulties in producing certain sounds, and irregular spelling patterns associated with medical terminology created difficulties with pronunciation.

Rose experienced problems pronouncing the phoneme /p/ and thus the words 'pain' and 'parent'. Her inability to pronounce these common words clearly enough for patients to understand caused her distress; she felt that this breakdown in communication might cause her to fail the placement:

Some way I doing the interview with client is still they can't understand what I'm saying, "The pain, what your pain score?" ... When they can't understand me I will very, oh I don't know, very sad, because where I study

there in a hospital. I don't want will fail the paper.  
(Rose 2)

Anxieties such as these were compounded by negative reactions from others. In these cases, students became hesitant to initiate conversation, and before speaking to each new person wondered 'What if they don't understand me?'

Speaking to senior members of staff, or those perceived to be in authority, was especially challenging as it required the use of medical terminology. Whilst students might understand the terminology when spoken or written, working out how to say it could be extremely difficult:

A lot of medical words I understand what they mean but I can't pronounce very well. It's hard for me to pronounce. Especially for the medication's name ... Because it not really follow English pronunciation rule ... I don't know what it sounds like. Once I know, I can copy very quick.  
(Sylvia 2)

Although they were able to read medical terms and understand them when used by others, students were unable to pronounce them without a model to follow. This impacted on their confidence to engage in routine, formal activities such as handovers, thus marginalising them from the interactions that would support learning.

### **Comprehend Others' Speech**

Understanding and acting on what is said to you is a vital part of safe practice for a nurse. Students must understand their colleagues' verbal instructions and reports; they must also attend to patients' informal speech in order to identify important information and arrange appropriate care. Understanding speech is also, of course, integral to maintaining the conversations that are such an important part of the nurse's work.

Most of the students in the study had problems understanding others due to fast rate of speech, unfamiliar vocabulary (particularly slang and idioms, or colloquial terms), and unusual accents (for example when working with overseas staff). From the clinical lecturers' point of view, students' tendency to cover up lack of comprehension rather than request clarification was a major problem.

Clients' use of lay-medical terms such as 'mumps' and 'chicken pox' had caused difficulties for some students when completing a health history: details of the client's medical background recorded on a standard form. Colloquial expressions were another area of concern. Jo, for example, was confused when a patient asked to be taken to the 'loo', and had to ask for clarification before realising that this was a familiar term for 'toilet'.

Items of general vocabulary associated with the ward environment (for example 'face flannel') could also cause confusion if students weren't familiar with them:

I just know it's a towel. I don't know face flannel, or hand towel, or something like that. So it's just hard when the nurse ask me, "Okay, grab the face flannel", just like that. Oh, what that? No idea. So it's very hard at first. (Rose 1)

These common expressions are taken for granted by native speakers as part of background knowledge, but may present challenges for ESL students.

Insufficient knowledge of pragmatic rules of English, in particular how suprasegmental aspects such as intonation and word stress are used to convey illocutionary force, can lead to misunderstanding. During our first interview, Rose described the experience of failing a previous placement. In her view, this was because she had misinterpreted the supervising nurse's question as an invitation. While the supervising nurse was trying to draw attention to the fact that Rose should *not* give an IV injection at this stage of her training, Rose perceived the nurse's pointed question 'Do you *want* to do that?' as a straightforward invitation to perform the procedure (signalled by the words 'Do you want...'). Moreover, this invitation was from someone in a position of authority. She had failed to pick up that the stress placed on the word 'want' changed the illocutionary force from invitation to warning. This incident had been hugely upsetting for Rose, resulting in significant financial cost and loss of confidence.

Rather than attempting to clarify their understanding, students sometimes used strategies such as avoidance, 'guessing', or pretending to understand, in order to avoid appearing incompetent, which would threaten their developing identity as legitimate members of the nursing community. These strategies are potentially dangerous and can compromise patient safety. The clinical lecturers

described several incidents where ESL students failed to clarify their understanding of an important instruction. Incidents such as these illustrate the critical importance of both student and preceptor understanding and implementing strategies to check understanding.

### **Understand Kiwi/New Zealand English**

Participants in the study all felt that understanding 'Kiwi' speech (defined as speech that included New Zealand cultural references, colloquialisms, idioms and humour) was important in order to identify important information, for example when taking patients' health histories, and to enable students to engage in social conversations with patients and colleagues.

Students were aware that this was an area of difficulty for them :

When the patient want to make a joke, for example, or to show they really relaxed, or they not really care or something, they will say something very fast with some special words, but for me I am not really understand. ... I want to know like whether they are happy with my service or what they want or what do they mean when they say it. (Bobbi 3)

### **Use Medical Terminology Correctly**

In addition to general medical and nursing terminology, students needed to become familiar with the specific terminology of the ward or clinical setting, including common acronyms and abbreviations. As the clinical lecturers noted, this could be a tall order:

L2 – If you're in an orthopaedic ward, for example, which is about bones and things, they're talking about 'nofs' (which is a fractured neck of femur) ...

L1 – abbreviations ....

L2 – ... And people just talk about things. They just talk in that way, you know, like, "We've got another 'nof' coming in, blah blah blah". If you're in theatre it's a totally different language there and then you're out in the primary health care setting, and then you're in a paediatric setting ... for us it's the

equivalent of turning up into Istanbul and being expected to function effectively. (L)

During her first week in the operating theatre, Jo found it particularly challenging to learn the names of the surgical instruments:

So honestly, I had a hard time this week. Most of all, it is difficult for me to remember the name of all the instruments. There are many instruments such as BP handles, Adson, McIndoe, Crile, Devacky, Iris, Mosquito, Artery forcep, Alice, Quiver, Langenback, little woods, trevors. Even Iris has three types; Curved Iris sharp, Straight Iris sharp, Curved Iris blunt. (Jo email 24 August)

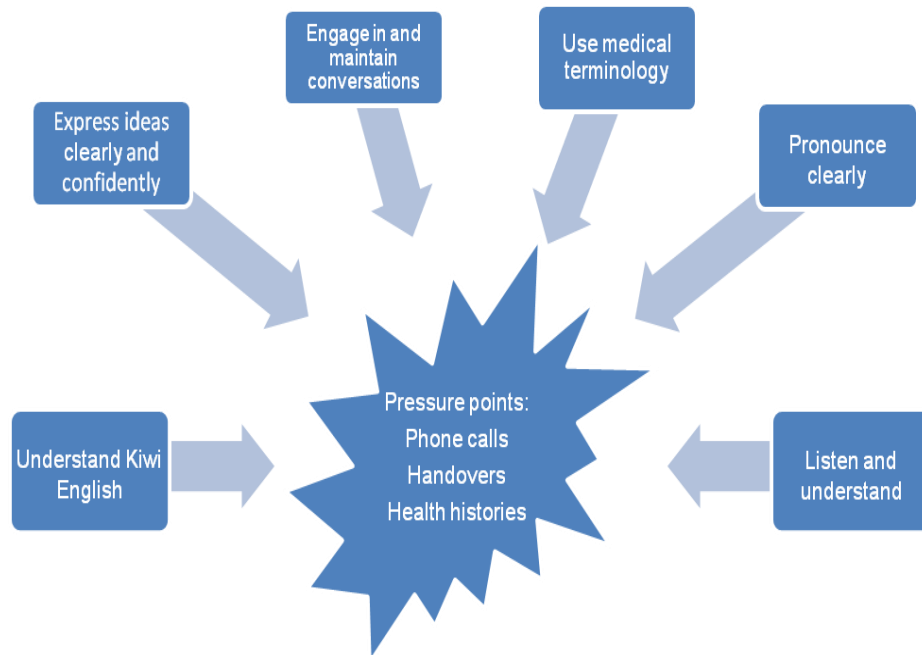
Although all students would probably find mastering each new set of terminology difficult, ESL students face the extra challenge of achieving this in a second language.

All seven students found talking to doctors or other senior staff stressful, because it involved using, understanding and pronouncing medical terminology. They were aware of their difficulties with medical terminology, and were keen to improve, often going to great lengths to practise the terminology in their own time, outside the placement.

### **Pressure Points**

Certain routine situations such as making telephone calls, taking health histories and engaging in handovers caused students to experience high levels of language anxiety. In these situations, students needed to bring together and use several challenging aspects of English, under pressure of time, and often in a public arena (see Figure 4.3 below). During the focus group, the lecturers described how these situations could negatively affect students' language performance:

If they were an IELTS seven, they'll revert back to an IELTS five immediately because it's now stressful ... they what we would say is 'lose it' because they haven't got the skills communication-wise to cope with that additional stress. (L)



**Figure 4.3: Pressure points for communication**

This section has summarised data on the importance of English language proficiency to effective communication in placement, and has described some of the major factors involved in this proficiency. The language demands of the placement setting are complex, involving formal and informal registers, the ability to translate between medical and lay-medical vocabulary, and engagement in both social and transactional interactions. These demands are summarised in Figure 4.4 below.

Informal			Formal		
<b>Social conversations with colleagues</b>	<b>Social conversation with patients</b>	<b>Health assessments</b>	<b>Working with patient</b>	<b>Telephone conversations</b>	<b>Reporting/Handovers</b>
<ul style="list-style-type: none"> <li>• purpose and importance of small talk in NZ workplace</li> <li>• timing of small talk – acceptable and unacceptable</li> <li>• informal register</li> <li>• discourse style</li> <li>• greetings</li> <li>• conclusions</li> <li>• topics of conversation</li> <li>• strategies to extend conversation</li> <li>• negotiation of meaning</li> <li>• humour</li> <li>• colloquialisms</li> <li>• idioms</li> <li>• cultural references</li> </ul>	<ul style="list-style-type: none"> <li>• greetings</li> <li>• conclusions</li> <li>• topics of conversation</li> <li>• strategies to extend conversation</li> <li>• humour</li> <li>• colloquialisms</li> <li>• idioms</li> <li>• cultural references</li> </ul>	<ul style="list-style-type: none"> <li>• lay medical terms</li> <li>• strategies to clarify comprehension</li> <li>• listening to identify main points</li> <li>• medical vocabulary</li> <li>• translating from medical to lay-medical terms</li> <li>• colloquialisms</li> <li>• humour</li> <li>• idioms</li> <li>• abbreviations and acronyms</li> </ul>	<ul style="list-style-type: none"> <li>• softening directives and instructions</li> <li>• lay-medical terms</li> <li>• translating between medical and lay-medical vocabulary</li> <li>• everyday vocabulary</li> <li>• colloquialisms</li> <li>• cultural references</li> <li>• idioms</li> <li>• humour</li> </ul>	<ul style="list-style-type: none"> <li>• openings and closings</li> <li>• discourse style</li> <li>• listening to identify main points</li> <li>• requesting clarification</li> <li>• public performance</li> </ul>	<ul style="list-style-type: none"> <li>• general medical terminology</li> <li>• medical terminology relevant to setting</li> <li>• abbreviation and acronyms</li> <li>• clarifying information</li> <li>• listening to identify main points</li> <li>• exposure to public performance</li> </ul>
Pronunciation Volume of speech Body language					
<b>Social</b>			<b>Transactional</b>		

Figure 4.4: Summary of language demands on placement



## **4.2 Intrinsic Factors: Proactive Approach to Learning**

The proactive approach to learning expected on placement requires confidence, the ability to be assertive and negotiate with those in authority, and a clear understanding of your right to learn from others. This approach is akin to the personal agency that enables students to facilitate their own access to the interactions of the community of practice (Toohey & Norton, 2003).

Learning styles differ across cultures (Choi, 2005, p.266). While the accepted style in New Zealand focuses on an independent, proactive approach, some cultures prefer to work collaboratively, with all members of the group learning together, and others view students as passive recipients of knowledge provided by the teacher. Students from cultures that traditionally take a more teacher-led approach to learning may find exercising personal agency in negotiating access to the interactions of the placement challenging, especially if they have not adapted to an active learning style.

Several key learning approaches or strategies associated with successful communication in clinical placement emerged from the data. These were strongly associated with a proactive approach and included asking questions, seeking and responding to feedback, and acting assertively. Identifying primarily as a nursing student rather than as an ESL student also had a positive impact.

### **Asking Questions**

All students expressed some level of difficulty in asking questions, due to cultural norms around communicating with teachers or those in authority:

The way I was brought up, we don't like to interrupt people. ... The teacher talk, you don't talk. We need to highly respect my teacher as a authority. ... I respect my preceptor, so maybe that's why I don't feel that is right or uncomfortable to stop people. (Sharon 1)

Some students also felt that asking questions might reveal a lack of understanding, which might then threaten their acceptance within the

community of practice. All students, however, recognised it as an important strategy even if they were not comfortable in adopting it. Some, such as Sharon and Bobbi, had made a conscious decision to start asking questions in order to learn and to ensure safe practice. However, it had taken a long time – nearly three years of study – and encouragement from teachers and placement staff to reach this point. This growing realisation was reflected in students' responses when asked what advice about clinical placement they would give to a new ESL student. In the first interview the majority of the students mentioned ability with English; when asked the same question at the end of their placement, however, their responses centred on the importance of asking questions. It was only through direct experience in the placement that they were able to translate passive acceptance of the importance of this strategy into direct action.

### **Seeking and Responding to Feedback**

Most students in this study found it difficult to seek feedback from the preceptor as it involved interrupting a busy professional and asking for personal attention. These actions carried the risk of a negative response, which might then threaten students' confidence as legitimate members of the practice team.

Visits and feedback sessions from clinical lecturers are opportunities for the student to talk about how the placement is going, and to air any problems. Some students found this process very challenging. Bobbi felt that during her first two years of study, she couldn't have spoken about problems with the placements; she would have had to "Say all the good things and handle the bad things" (Bobbi 1), because talking about problems would be disrespectful to her teachers.

### **Acting Assertively**

Being able to act assertively and negotiate access to learning experiences were seen by lecturers and preceptors as desirable qualities for students in placements. The clinical lecturers felt that preceptors preferred students who

could adopt an assertive, proactive style, including the ability to initiate conversation, and that this style was problematic for some ESL students who had a more passive approach:

L3 - They like a student who'll smile and greet them, show initiative.

L1 - Is reasonably articulate, you know, is proactive in doing things and stepping forward, and that's not part of their culture . (L)

Assertive students who were able to 'put themselves out there' and negotiate their own learning paths were more likely to be chosen for challenging or exciting tasks, such as going to meet a patient arriving by helicopter. As a result, assertive students might be exposed to extra or different learning opportunities, and consequently develop wider sets of skills.

For most of the students in this study, however, being assertive was problematic. It was not a valued trait in their culture, and they did not understand how to go about it. Sylvia, for example, recognised that being assertive was important, and had tried to adjust to an assertive style. Even though she felt she had made good progress, this was not recognised by those she worked with. Their feedback was that she needed to be still more assertive:

My preceptor she just keep on encouraging me to be assertive. Because she said to me, "You are shy." But I don't know because since I came to New Zealand, I already become more confident to talk to people, but she still think it is not good enough. (Sylvia 3)

For Sylvia, attaining the assertive behaviour required on placements seemed an almost impossible attainment.

### **Identifying as a Nursing Student**

Students tended to see themselves as different from 'Kiwi' students, and attributed difficulties in placement mostly to the challenge of working in a second language. For example, Jo referred to herself as "just international student" who needed extra time to become familiar with the language required in placement. Anna felt she must explain to her preceptor "Because

I have English as a second language, I'm a bit slow" (A1). Tina often referred to herself as a "second language student" and described how this had resulted in difficulties in being accepted by others in the placement environment.

Two students viewed themselves differently. Joey and Sharon identified primarily as nursing students, rather than ESL students. They each described situations where clients had difficulty in understanding them. In each case the preceptor immediately attributed this to the student's English proficiency, although the patient was subsequently found to have a hearing impairment. On the basis of experiences such as these, Joey advised ESL students not to accept others' assumptions: "Don't just assume, 'Oh, it's just my English'. Don't ever think like that. When I go out there, I'm just a nursing student. I don't see myself as an international student" (Joey 1). This positive attitude seemed to contribute to a smoother and more effective journey through the placement.

### **4.3 Extrinsic Factors: Effective Preceptor**

The two preceptors interviewed for this study had been asked to take on the role by senior staff. Despite clear recommendations from nursing bodies such as Nurse Education in the Tertiary Sector and Nurse Executives of New Zealand that preceptors should receive training for their role (NETS/NENZ, 2007b), and the availability of suitable programmes such as the Certificate in Preceptorship, neither of these preceptors had received this. However, they had developed their own clear ideas about the role of a preceptor, which they described as one of supporting and guiding students to become independent, competent and confident nurses, autonomous in their practice.

#### **Student Perceptions of 'Good' Preceptors**

The students valued preceptors who were inclusive, approachable, encouraging and who had effective teaching strategies. A preceptor with these qualities could greatly increase students' confidence and willingness to

interact with others, and facilitate their integration within the placement setting.

### ***Inclusive***

Students appreciated a preceptor who was welcoming and inclusive, gave a thorough orientation to the clinical area, and helped them feel part of the team:

Some preceptor they are really caring, even though just a tiny, little thing, they will think about you. Let's say when they go for break – some good preceptor, they will say to you, "Oh [Sylvia], let's have a break together." But I miss some preceptor. They just go by themselves and leave you behind. Then you are wondering, "Oh, where are they? What should I do?" (Sylvia 1)

In contrast, preceptors who displayed negative attitudes towards students could block their participation in the community, and damage their confidence and growing identity as nursing professionals. On an earlier placement, Bobbi's preceptor greeted her by referring to the poor English language skills of a previous ESL student. This signalled an expectation of inadequacy and an associated lack of membership of the practice community. This situation had a powerful impact on Bobbi's attitude to the placement:

I was shocking. Because I thought even though it was true, but you don't really need to tell me, 'cos it is my first day, in the morning, I'm so happy and looking for my clinical placement here. (Bobbi 1)

Bobbi's initial enthusiasm for the placement was squashed by the preceptor's attitude, which confirmed her view that some preceptors do not like working with ESL students.

### ***Approachable***

It was important that the preceptor was approachable and reacted positively to the student's requests for help. A negative response might prevent the student from asking further questions. One of the preceptors in the study made a conscious effort to support her student's requests for help or clarification:

If she didn't understand something, she didn't feel belittled or anything like that in any way to come and say to me, "I didn't quite understand that, could you explain it?" I was never judgemental or anything of her and it's not for good learning, being like that. (P1)

### ***Encouraging***

Preceptors who consistently provided encouragement were valued by students. This encouragement might take the form of reminding the student of how well they had done, and how much they had achieved, rather than focusing on negatives. It might also involve gently reminding the student that they were on a learning journey and should not expect too much of themselves. Sylvia remembered being encouraged by a previous preceptor: "I told her I still have lots of medical term I don't know, and she said to me, 'Don't worry about it, you can work on that.'" (Sylvia 3)

On the other hand, a critical preceptor could make a placement very stressful. Sylvia described a previous placement, where the preceptor constantly found fault and gave negative feedback in front of colleagues and clients. This had affected Sylvia's learning:

I can't learn anything. And also the atmosphere is not nice. You feel pressure, and how can you learn? And you don't want to go to the workplace and get someone keeps on telling you off. (Sylvia 3)

Other factors also affected students' learning. Some preceptors assumed all communication problems were due to students' lack of English, rather than looking for other possible explanations. Others assumed ESL students would not be able to communicate, so 'took over' rather than encouraging the student to take part in the interaction.

### ***Active Teaching Strategies***

The data revealed two broad categories of preceptor styles. The first might be called 'active' preceptorship – those who formulated deliberate strategies to guide students and teach them. The second was 'passive' preceptorship. In this category, there were two main types of behaviour: some preceptors

assumed that learning was the student's and lecturer's responsibility, and so were passive in their approach, giving little input; others 'took over' and completed tasks without giving the student the opportunity to engage in them, thus rendering the student passive rather than facilitating active participation.

The students had a strong preference for preceptors who took an active teaching role, using deliberate teaching strategies. These preceptors gave direct instruction, modelled desired behaviours, and checked students' understanding.

- **Giving direct instruction**

Although students recognised 'self learning' as important, they wanted the preceptor to give them direct instruction and feedback at times, especially when they were under pressure.

- **Modelling**

Demonstrating what was required was more effective than talking about it. Preceptors who modelled a procedure or communication strategy were valued by students. Tina found observing other nurses particularly helpful in dealing with difficult patients:

When you standing there, hearing how ... observing how the nurse dealing with the demanding patient, how they use the language to comfort the patients, it's really helpful for you to learn you know what they say. (Tina 2)

- **Checking students' understanding**

Checking students' understanding by asking them to verbalise what they had understood was an effective strategy and helped to clarify misunderstandings. Jo, for example, found this strategy much more helpful than just being asked if she had understood.

Sometimes another nurses they just ask me, “Is it okay?” or they ask me yes or no question: “Do you understand?” “Yes.” Sometimes that situation doesn’t help me to really understand the situation. (Jo 1)

#### **4.4 Extrinsic Factors: Supportive Environment**

The overall ‘tone’ of the placement had an impact on students’ level of confidence in interacting and communicating. A positive, accepting environment encouraged students to engage with its practices and interactions, whereas a critical or discriminatory environment tended to shut down the students’ efforts to interact.

All the students in the study reported incidents of negative attitudes in placements, from staff members such as nurses, care assistants, doctors and other health professionals, and from patients.

#### **Discrimination in Placements**

In the clinical lecturers’ view, discrimination is a major challenge for ESL students in placement. Some staff members in placements have preconceived ideas about ESL students, believing that they will be problematic, have special needs, and be less successful than their Kiwi peers.

Clinical lecturers described their experiences of senior placement staff reporting on ESL students. Statements such as “*Even \_\_\_ seems to be doing okay*” suggested that, in their view, it was unusual for an ESL student to succeed. It was also common for placement staff to define ESL students by their cultural background (for example by referring to them as ‘The Malaysian student’, or ‘The Indian student’), rather than as part of the wider group of nursing students.

Preceptors’ previous experience with or preconceptions about ESL students could result in differential treatment during placements:



L3 - Often preceptors feel they've got more right to tell these students what to do and how to do it than they would normally.

L3 – It's like if they're wearing white running shoes, the preceptor will easily say, "Oh! Now, what's this?" and will challenge the fact they've got the shoes on. If that was an assertive young white Kiwi, they would never bring it up. That's what I'm thinking. They're more likely to say to an English second language student, "Right. Lunch now, please," whereas again, they may negotiate that with the other student. It's that sort of behaviour that I'm thinking.

L1 – Altered behaviour.

L4 – And it's unconscious. (CL)

Although, as mentioned previously, the students in the study sometimes preferred the preceptor to give direct instruction and teaching, they implied that this was within an atmosphere of support, respect and encouragement, and in the context of increasing their practical skills. The behaviour as outlined above suggests that some preceptors used an altered manner with ESL students that was overbearing rather than considerate.

### **Negative Attitudes from Colleagues**

During the focus group, lecturers agreed that the placement environment could influence students' access to learning: if students did not feel welcomed or accepted, they were more likely to withdraw and avoid communication:

L4 - They don't feel safe to communicate.

L5 – And that's part of the ward environment.

L2 - Safety to ask.

L4 – Yeah. Their safety to ask. Their feeling of being okay to ask. (CL)

In Bobbi's view, while health professionals were aware of and respected the cultural beliefs of patients, this awareness and respect did not extend to students or colleagues:

They never thought maybe some things if they say is very offensive for me. I mean they understand, but the understanding is only for the patient, only for their own. It doesn't cover me. (Bobbi 1)

In some placement environments, there was little evidence of sensitivity towards and understanding of the backgrounds and beliefs of students from other countries and cultures.

Some patients also had a negative attitude towards ESL students. Lecturers and preceptors agreed that elderly patients, in particular, often preferred not to be treated by ESL students.

### **Supportive Environments**

All the students in the study gave examples of individuals who had taken time and effort to 'go the extra mile' for them, and who had shown an interest in their background and culture.

In the clinical lecturers' experience, placement environments that included staff from other cultures, and where there was respect for these staff members, were the most positive environments for ESL students:

One ward that I work in, probably the top, most respected nurse in that setting is an African nurse, who is meticulous in her practice ... . I think the ward has respect for people of other nationalities because of that, whereas I have another ward ... and I have always have a problem on that ward, cos they're very unwelcoming to students of different nationalities and it appears to be that whole racism thing that comes down from the top. (CL)

A welcoming atmosphere could dramatically affect the quality of the student's learning. The transition to practice placement was Bobbi's best experience, because she felt welcomed by her colleagues. This acceptance as a team member boosted her confidence and enabled her to relax and learn: "People they treat me like a real team member and then they will like to work with me and also I can learn from them so it's really good, it's really, really good" (Bobbi 3).

These encouraging attitudes and responses from others built confidence, which in turn led to further interaction, thus creating a positive cycle of growth.

#### **4.5 Conclusion**

The students in this study willingly and openly shared their experiences of clinical placements and in doing so allowed me to participate vicariously in their journey. Each journey was unique, as the individual concerned negotiated access to this new environment and began the path to confident communication within it, all the while coping with the demands of a second language. Each journey involved both positives and negatives, but each ultimately resulted in a successful outcome. By the time of the third interview, some students had already been offered positions in New Zealand as new graduate nurses.

Each student brought a unique set of characteristics to a particular context, and the way in which these interacted contributed to the student's experience. By comparing data from all participants, four main factors could be identified as supporting the student's growth to confident and effective communication within placement. English language proficiency, especially in the kinds of English that were essential for placement, was the most critical factor. Other factors such as approach to learning, the choice of preceptor and the relationship with other colleagues were also important.

Each student needed to develop confidence in their own competency, in order to engage with the interactions of the placement and so begin the movement from peripheral to full participation in the community of practice. As students felt that their efforts to communicate were supported, accepted and had positive outcomes, their willingness to interact with others tended to increase, leading to further confidence, more interactions and thus gains in language competence. All the factors above affected student's level of confidence and their ability to access the interactions that were crucial to language growth.

## 5 Discussion and Implications

### 5.1 Question One:

#### ***What are the factors that facilitate effective communication in clinical placement, for ESL students?***

Four main factors that facilitate effective communication were identified in the study. These were classified as either intrinsic (factors under the control of the student), or extrinsic (factors inherent to the placement environment). The discussion that follows examines the significance of each factor.

#### **Intrinsic Factors: English Language Proficiency**

This study supported the view (for example Holmes & Major 2003) that the English required for competent communication in placement is complex and sophisticated. It requires ability with both formal and informal registers, an understanding of New Zealand English, and familiarity with both medical and lay-medical vocabulary. Nursing can be a high-pressure occupation and coping with its interpersonal demands in a second language can be extremely challenging.

In the context of Bachman's model of language competence (1990, p. 87), the findings of this study reveal the particular importance of pragmatic competence to effective communication within a clinical setting. Particular aspects of organisational competence such as vocabulary and pronunciation (phonology) were also found to be both important and problematic for second language students.

#### ***Organisational competence***

The participants in this study consistently ranked grammatical accuracy (ie use of correct forms: Bachman's categories of morphology and syntax) as less important than fluency.

However, clear pronunciation (phonology) was considered important, perhaps because it directly affected students' ability to be understood by their patients and colleagues. Students were especially concerned about their pronunciation; students who struggled with pronunciation were constantly on edge in case they would not be understood. This made particular interactions particularly stressful, such as talking on the telephone, or communicating with senior colleagues in formal situations such as patient handovers.

Knowledge of the vocabulary used in the placement setting, especially technical vocabulary and its pronunciation, also emerged as a critical factor. While pronunciation of some medical vocabulary, especially names of drugs or chemicals (for example 'erythromycin' or 'sulfafurazole') would most likely be problematic for native speakers, words that did not follow English spelling or pronunciation rules were particularly troublesome for these students. This had a direct effect on their confidence, particularly on their willingness to interact with those in authority such as doctors, surgeons and senior nurses.

### ***Pragmatic competence***

Pragmatic competence as defined by Bachman (1990) emerged as both particularly important to communication in placement and as an area of difficulty for ESL students. In their interactions with patients, colleagues, families, other health professionals and senior staff, students had constantly to assess which form of language to use, to achieve the intended purpose in a way that was appropriate to the person being addressed and to the context. In order to do this, they needed both illocutionary and sociolinguistic competence.

- **Illocutionary competence**

Students constantly had to direct clients towards certain activities (to get up or turn over, for example) or ask them important questions (for example, what level of pain they were experiencing). To achieve this,

students needed to know both *what* form of language to use, and also *how* to adjust it to achieve the intended purpose. For example, while the imperative ‘Get up now!’ might have been an appropriate form for a request, it was not appropriate for use with a sick client in the context of a shared medical ward. Inability to ‘soften’ directives, for example by the use of hedging devices, mitigators and downtoners such as ‘just’, or ‘darling’ (“We just need you to get up now, darling”), caused some students in the study to be viewed as rude or abrupt; this hampered their ability to ‘fit in’ to the workplace, and so constrained their access to further interactions and full participation in the community of practice. This adds weight to Riddiford’s (2007) view that native speakers are often unaware of the complexity of the underlying rules and norms of their own language, and so perceive ESL students who make such pragmatic errors as simply being rude:

For a L2 learner of English in an English-speaking environment, the consequences of failing to express a request appropriately can be serious. These consequences can be even more severe if the L2 learner has a good command of the formal features of the language and is operating in a professional capacity. In these circumstances the risk that inappropriate forms will be attributed to rudeness is significant. (2007, p 91)

Illocutionary competence was also needed to correctly interpret instructions given by others. For example, the statement “Mrs. Jones needs the toilet” could also function as an observation or a direct instruction, depending on the manner and context in which it was said. In order to ensure patient safety, correct interpretation of the illocutionary force of others’ speech is essential.

- **Sociolinguistic competence**

The data from the study clearly underlined the importance of sociolinguistic competence. The students on placement dealt with a range of people and contexts, and knowing how to use language

appropriately was essential. An ability to select and use both formal and informal (or casual) registers was important. Use of the formal register, for example when interacting with senior staff in the context of patient handovers, was hindered mostly by lack of confidence with technical vocabulary, as outlined above. The informal register, which clinical lecturers and preceptors clearly identified as an integral part of establishing effective therapeutic relationships with clients and effective collegial relationships with other staff, was more problematic for students.

The study highlighted the importance of initiating and maintaining these informal conversations or 'chats' with both patients and staff. The main area of difficulties for students were selecting suitable shared topics of conversation and understanding New Zealand cultural references, figures of speech and humour. Understanding these cultural references (and lay-medical terms used in New Zealand) was vitally important so that students could pick out essential information from their patients' speech. Students who had previously worked as nursing assistants in New Zealand were more confident about interacting with their patients than those who had no experience in the health professions outside the programme of study.

Informal interactions with staff were a critical part of successful communication in placement, with three of the students being given direct feedback to improve their interaction with other members of the team. This was difficult for students who were unaware of the expectation for and norms around social talk in the New Zealand workplace. Such students require explicit, focussed instruction in this aspect of workplace communication.

Students also needed to engage in formal interactions with other team members. They were more anxious about these interactions than about interactions with patients, as also noted by Bosher and Smalkowski (2002). This was largely due to reservations about the use and pronunciation of medical terminology and about revealing a lack of

comprehension. This could lead to students either avoiding communication with staff or failing to clarify essential information. Knowing when and how to interrupt someone who appeared to be busy also impacted on students' confidence in interacting with other staff members.

### **Intrinsic Factors: Proactive Approach to Learning**

To learn effectively in the clinical placement, including learning the norms of communication, students needed to exercise personal agency in negotiating access to learning opportunities, through taking initiative, asking questions and assertively seeking opportunities for interaction and feedback. Students who displayed this approach were favoured by preceptors, perhaps because they were perceived as easier to work with, and less demanding in terms of time and attention. This assertive, proactive approach was problematic for the majority of the students in the study, who came from cultures that traditionally espoused a more passive, teacher-led approach to education.

Although students recognised the importance of a proactive assertive approach, they did not necessarily know how to go about it. Asking questions might be interpreted as revealing a lack of comprehension, with associated embarrassment or loss of face, and it was also difficult to know when and how to interrupt someone in a busy environment. Acting assertively was problematic for students for whom this was culturally inappropriate.

By the end of the placement, however, most of the students had tried to adopt an active approach to some degree. Often, a change had come only in response to a critical moment when failing the placement became a possibility. When these students were given explicit and direct instruction on the changes they needed to make, they were able to adopt new strategies and change their approach.

This proactive approach is clearly an example of the notion of agency (Toohey & Norton, 2003). Adopting an active approach enables students to



act on their environment in order to facilitate access to the interactions and models of expert performance that enable them to learn the communication patterns of the community.

### **Extrinsic Factors: Effective Preceptor**

In the students' view, the choice of preceptor was 'make or break' to their placement experience – a supportive preceptor could help a struggling student build up confidence and the sense of competency that enabled participation, whereas a critical one could cause stress, self doubt and withdrawal.

The preceptor can play a crucial role in facilitating and scaffolding the student's entry to the community of practice, including its language and patterns of communication. Preceptors act as guides and role models for students, and are influential in providing them with models of expert performance and opportunities to practise communication strategies. These responsibilities imply an active, rather than a passive role.

The students in the study were able to describe the qualities of an effective preceptor, and these were echoed by the two preceptors who were interviewed (both of whom were described by their students as displaying an active style). These qualities include an encouraging, supportive and non judgemental approach, with the ability to provide clear feedback and direct, positive instruction when required.

While the preceptors interviewed as part of the study had a clear understanding of their role, students all described experiences of working with other preceptors who were passive, critical or unsupportive and who had the potential to undermine students' confidence, learning and self-identity as future nursing professionals. This underlines the critical importance of effective and compulsory training programmes for preceptors. Heavy workloads, lack of time, and preconceptions about ESL students were other factors that could negatively affect the preceptor's attitude and approach.

## **Extrinsic Factors: Supportive Environment**

The 'tone' of the placement was important in either facilitating or hindering the student's entry to the community of practice and its communication patterns. A supportive environment that was welcoming and inclusive, and where the student was included as part of the team, had a positive effect on the student's willingness to interact with others and so develop communication skills. By welcoming the student, staff members afforded students legitimacy within the setting and so provided them with greater opportunities to access its practices.

The clinical lecturers reported that some staff in clinical settings held preconceived and stereotypical views that could result in differential treatment for ESL and non-ESL students. These staff members were more likely to react negatively to ESL students' questions and requests for clarification, with the effect of marginalising students from the interactions of the community, and causing a loss of confidence. The tone of the placement setting often came down 'from the top', and was often more positive and accepting when staff came from a variety of cultural backgrounds.

As well as providing information on intrinsic and extrinsic factors that influenced students' communication in placement, the data also highlighted the role of confidence in the development of successful communication.

## **The Role of Confidence**

When students engaged in interaction that was successful, their belief in their ability to communicate rose. This increased sense of self-efficacy, or belief in their own capabilities, led to greater confidence and willingness to communicate (Mills, Pajares & Herron, 2006; MacIntyre, Dornyei, Clement, & Noels, 1998). This confidence then contributed to the students' ability and motivation to exercise personal agency in negotiating access to further interaction. With interaction came access to models of expert performance in communication, and so a gradual move towards language competency took place (Toohey & Norton, 2003).

The data suggest that the intrinsic and extrinsic factors listed above work together to support students' sense of competence, their willingness to interact, and the likelihood of that interaction being successful. For example, if students have a high level of the English language proficiency required for placement, are able to employ a proactive approach to learning, have effective preceptors and are placed in a supportive environment, they are more likely to have the confidence and ability to interact with others, and the personal 'agency' to negotiate access to social networks. These factors also influence their sense of legitimacy within the community of practice, and their growing identity as future nursing professionals. At the other extreme, students with low levels of the English proficiency required for placement, who are passive in their approach to learning and who are assigned ineffective preceptors in an unsupportive environment are likely to be anxious and hesitant in their interactions, and to lack the skills to negotiate access to learning experiences. Their position of legitimacy in the placement may be threatened or blocked, resulting in limited access to the models of expert performance that they require in order to move towards competent communication. This warrants further discussion: these factors can be used to guide the development of undergraduate nursing programmes that will effectively facilitate students' induction into the requirements of the nursing role, and provide adequate guidance and support as students take on new identities as nursing professionals in New Zealand.

It is important to note that the student's access to interactions within the placement is also the responsibility of other parties involved. Models of workplace learning (Lave and Wenger, 1991; Billett, 2001) emphasise that in order to learn effectively, students need to have guidance from expert others, and structured access to the interactions of the community. This implies an active role from the 'expert others', including clinical lecturers and preceptors. This active role must include ensuring that the student has access to and opportunities to practise the interactions and communicative patterns necessary for competence. There are also implications for programme development, so as to ensure that all parties to placements are

aware of how the students' learning on placement will be scaffolded and structured.

While all students require structured support to facilitate their integration within the placement, some students are better positioned to achieve this integration. The two students in this study who had the smoothest journeys through placement shared several characteristics. On the two intrinsic factors, English language proficiency and a proactive approach to learning, they both appeared to be more competent than their counterparts. They also appeared to be able to exercise more 'agency' within the setting, in negotiating access to interpersonal communications. For example, Sharon took an active approach when presented with the opportunity of stepping in for a preceptor who was called away. This was a learning opportunity that gave her the chance to take full responsibility for patients early on in her placement, and so demonstrate her competency to others. She was confident in doing this, and in approaching other nurses for assistance: "If I was unsure, I just went to them" (Sharon, 1). As a result, she made great gains in her sense of competence, creating a positive cycle of increased confidence, interaction and learning. Joey was keen to seek out learning opportunities in her placement, and in particular to find ways of practising social conversations with clients. She was able to negotiate this with her preceptor, who helped her by providing 'debriefs' about clients before they arrived at the clinic. Joey also used personal agency in negotiating input from her preceptor, building a relationship where feedback was routinely given over a shared lunch.

Both Joey and Sharon were permanent residents in New Zealand, having settled here with their families, and so could be considered to have integrated to some extent with the New Zealand culture. These backgrounds ensured they had areas 'in common' with Kiwi students and other nursing staff, and so were perhaps more likely to be able to access social interactions and acceptance within the community of practice. These two students also identified themselves primarily as nursing students, rather than as ESL students. The other students, in contrast, were in New Zealand on

student visas, did not have family here, and tended to be positioned by others and themselves as 'different'.

### **Support for ESL Students**

As part of the study, all participants were asked what could be done, in their view, to help prepare ESL students for the communication demands of clinical placement. A summary of responses is shown in Table 4.2 below.



Type of support	How this could be achieved	Suggested by		
		Students	Lecturers	Preceptors
<b>Orientation to programme</b>	Specific orientation for ESL students, at beginning of programme, to cover special issues and support		✓	
	An overview of healthcare in New Zealand, including a flow chart of the 'full picture' and case studies	✓		
<b>Academic and pastoral support</b>	Lecturers, tutors or mentors with special responsibility for ESL students (preferably from ESL backgrounds)	✓		
	Pastoral and emotional support - many students were away from their family and friends.	✓		
	Facilitated support group to discuss problems with assignments or placements.	✓		
	Conversation groups.	✓		
<b>Preparation for placement</b>	A course to provide extra preparation for ESL students, with a focus on communication for placements.	✓	✓	✓
	More emphasis on communication as part of skills labs.			✓
	Preparation specific to each placement, for example elderly care or recovery.	✓		
<b>Inclusive environment, integration in programme</b>	Use ESL students' experience and cultural background as a resource within the programme.	✓		
<b>Time</b>	Flexible placements, with more time to achieve the required competencies. ESL students require more time to get used to the language and culture and to develop key relationships.	✓	✓	

**Table 4.2: Participants' suggestions for ESL student support**

## **5.2 Question Two: What are the implications for undergraduate nursing programmes in New Zealand?**

The findings of this study suggest that students for whom English is a second language require additional support to enable them to develop the skills necessary for effective communication within clinical placements. This support is necessary in order to ensure that the student can fully engage with the practices, including language use, of the placement environment.

Undergraduate nursing programmes can provide support for the student through the following:

- Specific instruction in the language and communication required for placement
- Orientation to and practice in a proactive approach to learning, and tuition in appropriate learning strategies
- Matching ESL students with appropriate, supportive preceptors/colleagues
- Fostering an inclusive atmosphere throughout the programme

### **Specific Instruction in the Language and Communication Required for Placement**

Students require specific instruction and practice in those aspects of English language that are particularly relevant for placement, and that are often problematic for ESL students:

- Sociopragmatic rules of New Zealand English
- Initiating and maintaining informal conversations
- Understanding 'Kiwi' English, including cultural references, figures of speech and humour
- Medical terminology (including lay-medical terms)
- Pronunciation

This instruction could be offered through a 'Communication for Placement' programme, along the lines of those described by San Miguel et al. (2006) and Hussin (2009); through online activities and support; and through workplace experience.



### **Communication for Placement Programme**

Such a programme might include the following characteristics, as supported by the data and the available literature:

- Be developed jointly by nursing faculty (including clinical lecturers) and language teaching specialists (San Miguel et al., 2006);
- Include specific instruction on sociopragmatic aspects of language such as softening of directives, through the approach of noticing, understanding, and practising (Riddiford, 2007);
- Include explicit instruction and practice in initiating and maintaining informal and formal conversations with patients and staff ;
- Use material that is as authentic as possible, so as to incorporate examples of 'real-life' speech, including New Zealand idioms, colloquialisms and humour. In the absence of recordings of actual medical interactions, material such as the TV 'soap' *Shortland Street* could be used for analysis of New Zealand idiomatic language and social conversations (see, for example, Grant & Devlin's (1996) teaching resource: *Kiwi conversation the 'Shortland Street' way*). Recordings of nursing role plays such as those published in *A guide for international nursing students in Australia and New Zealand* (Hally, 2009) would also be valuable sources of material;
- Incorporate students' own experiences as a basis for exploration of language problems/strategies (Jasso-Aguilar, 2005). A suitable model for this is described by Riddiford and Joe (2005), where a pre-placement 'block' of instruction was followed by weekly feedback sessions during the placement, allowing exploration of real-life, authentic communication issues . These authentic communication issues could then be used as 'case studies' in courses for future students;
- Include practice of 'pressure point' activities such as handovers, health histories and telephone calls;
- Use role play and practice with native speakers (for example, by using senior faculty staff to replicate working with those in authority, or

inviting volunteers to take the part of patients in unscripted health-history role plays);

- Allow students to develop 'chunks' of language that they can use automatically, for example, the opening 'Hi, how are you feeling today?' These chunks can help students when under pressure, allowing them time to formulate more elaborate contributions to conversations;
- Give direct instruction in asking questions, including requesting clarification, and in interrupting politely but assertively;
- Explore workplace expectations in New Zealand, and the clinical placement as a workplace;
- Include a focus on medical terminology, including common abbreviations and acronyms.

A variety of published language resources for ESL nurses and nursing students are available and could be used in the development of such a programme (for example Hally, 2009; Department for Education and Skills, 2005; Allum & McGarr, 2008).

### **Online Activities and Support**

Online, web-based support can provide students with opportunities to practise aspects of language in a non-threatening environment, and offers a useful complement to a face-to-face communication programme.

This online support could incorporate the following:

- Podcasts and video podcasts of medical interactions, to provide models of authentic communication in a New Zealand context. Whilst examples of authentic interactions might be difficult to obtain because of confidentiality issues, recordings of role plays might also be used (using New Zealand accents if possible).
- A glossary of medical terminology, with 'voice over' pronunciation and opportunities for students to practise;

- A 'nursing word of the week' podcast – along the lines of the 'academic word of the day' podcast offered by Massey University's Martin McMorrow (McMorrow, 2010);
- Vocabulary exercises, quizzes and games, using medical terminology. These could include, for example, matching formal medical and lay-medical terminology, or exploring idiomatic health-related expressions (for example, 'sick as a dog'; 'feeling crook');
- Background information on common placement environments, including the functions, main treatments or procedures, specialised equipment, responsibilities of staff, and specific terminology and abbreviations.

### **Work Experience**

'Apprenticeship' and social participation models of language learning (for example Lave & Wenger, 1991; Roberts 2001) imply a gradual induction into the practices of the community – learning the communication patterns appropriate to placements takes time.

The findings of this study lend support to the idea that employment in the health sector, for example as a caregiver or nursing home assistant, provides valuable practice for ESL students in the interpersonal communication that is required for clinical placements. This kind of work experience, where students are in a 'junior', supportive role, allows them entry to the community of practice from a position where peripheral participation is definitely legitimate. In these kinds of roles, there is less expectation from others of prior nursing knowledge, including knowledge and expertise in nursing communication. Therefore, there is also less danger of compromising students' emerging sense of identity as health professionals. How undergraduate nursing programmes might incorporate this work experience, for example as a structured element of the programme, is an area for further consideration. For example, students might be required to

complete a minimum number of voluntary or paid work-placement hours by the time of the first clinical placement.

Consideration might also be given to making extended placement time available for students, including ESL students, who require extra practice to acquire necessary communication skills.

### **Fostering Active Learning**

Students require support and encouragement to acquire the proactive strategies that optimise effective learning in clinical placements. A communication for placement programme as described above could incorporate aspects of communication essential to these strategies, such as asking questions, requesting clarification, and ways of interrupting politely.

A specific orientation programme (either face-to-face or online) for overseas students would also be beneficial. This programme, ideally either pre-enrolment or in the early weeks of the programme, could introduce necessary background information on New Zealand culture, an overview of the New Zealand healthcare system, the role of the nurse in New Zealand, New Zealand academic and workplace culture, and expected active learning styles and attitudes. It could be made optional for all students, with a strong recommendation for those from cultural backgrounds other than New Zealand to attend/enrol.

Mentors, dedicated academic support and student support groups (Brown, 2008) are other means that could be explored, to facilitate the uptake of a proactive approach to learning and use of associated learning strategies.

### **Placing Students in Supportive Environments**

The experience of the students in this study confirmed the importance of being allocated one preceptor for the whole of the placement, rather than multiple preceptors, in terms of continuity and building the rapport necessary for learning (Hussin, 2009).

Given the centrality of the preceptor's role to the student's learning in placement, it is important that preceptors receive explicit and formal training. It is recommended that formal mechanisms be put in place to ensure that preceptors working with undergraduate students have successfully completed appropriate (and required) training.

A suitable training programme for preceptors would include information on active preceptorship, including strategies to check understanding, model expected behaviours, provide instruction, give feedback, encourage and support students, and facilitate students' full access to nursing practices as legitimate members of the placement team. It is further recommended that content on working with ESL students is either included as part of the formal training programme for all preceptors or made an optional component, with only those preceptors who have elected to study this component being eligible to work with ESL students.

The study confirmed that ESL students benefit from working in placements and with preceptors that display an inclusive attitude and welcome diversity. In light of this, and the particular requirements that ESL students often bring to placement, consideration might be given to placing students only with preceptors who have a stated preference for, and interest in, working with this group, and in placements where there is known to be an inclusive climate.

Finally, providing a safe environment for students to talk about their experiences in placement, such as a facilitated support group, would enable students to explore and work through critical issues.

### **Creating an Inclusive Environment**

Although it was beyond the scope of this study, several students were keen to share with me aspects of their classroom experiences as a nursing student. They discussed feelings of frustration that their knowledge and cultural perspectives were not used in the classroom:

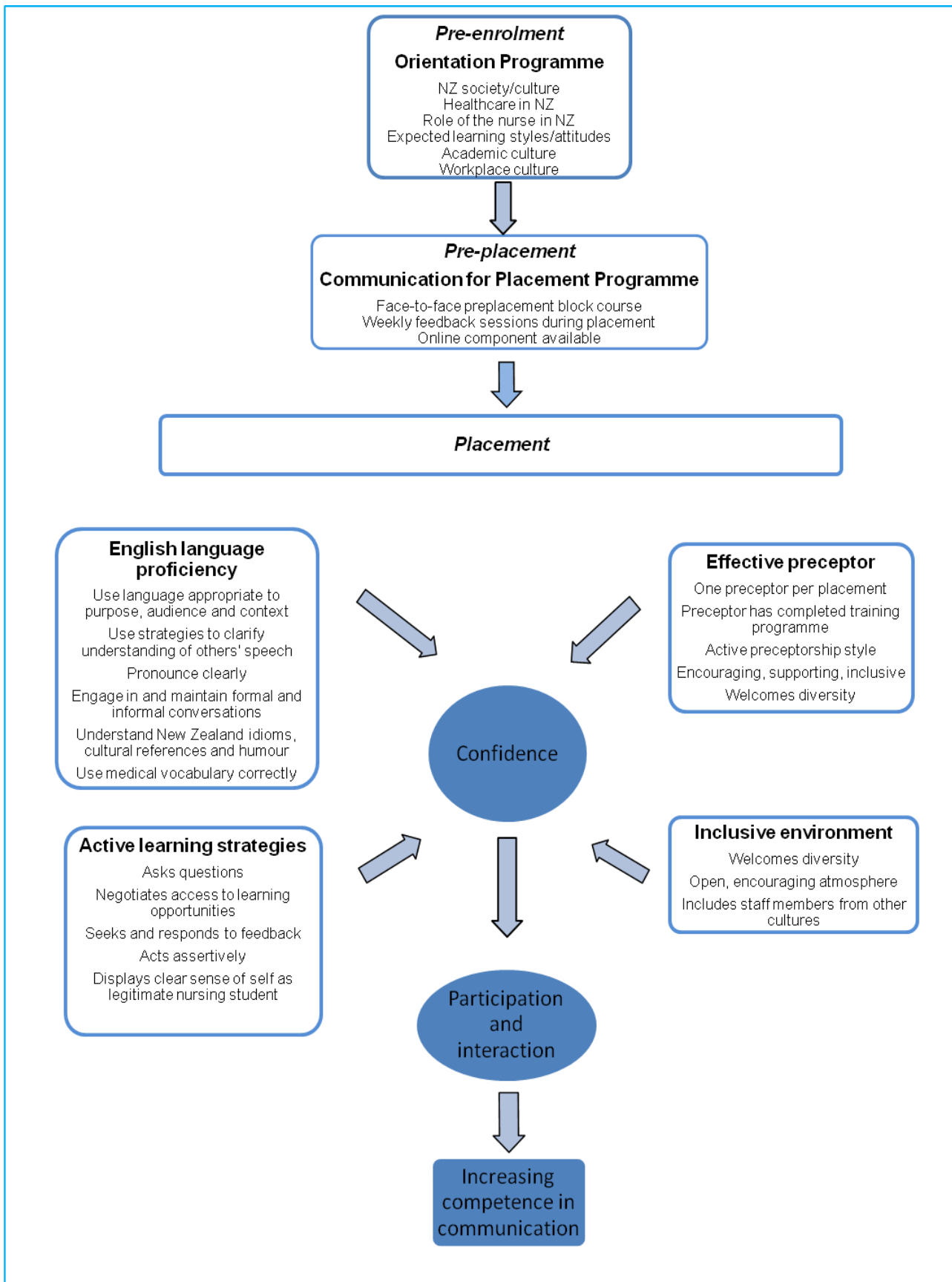
In the class I sit there and I look around, I think what a great opportunity in my class, like we have someone come from Korea, Japan and me, I come from China, and another girl come from Hong Kong and some of girls come from some island, islander, Philippines and Fiji and Indian, so I think it is a small picture, but represent the whole picture in NZ ... I think what a big waste. Why you don't use us? (Bobbi, 1)

In addition, students often felt alienated and excluded by their fellow students; this experience contributed to their view of themselves as different, as ESL students rather than part of the wider body of nursing students.

Creating an inclusive atmosphere throughout the undergraduate programme would provide validation for ESL students on the programme, and help them to identify more clearly with the wider student body. In many urban centres in New Zealand, the population includes a mix of cultures similar to that described by Bobbi in the quote above. Input from students from these cultures would be a relevant addition to the nursing programme. A shift to a more international perspective, with a focus on global as well as local issues and an opportunity to integrate ESL students' experiences, perspectives and cultural backgrounds in the programme in a positive way would benefit all nursing students, by providing them with a wider perspective and increasing their cultural awareness (Shakya & Horsfall, 2000; Omeri & Atkins, 2001; Malu & Figlear, 1998; Wang et al, 2008). Recruiting nursing staff representative of other cultures would also help to build an atmosphere of diversity and inclusion (Brown, 2008).

### **5.3 The Optimum Situation**

The results of this project can be used to predict an optimum combination of factors to facilitate ESL students' effective communication in clinical placement. The data from the project also provided information on the support mechanisms that might be put in place, prior to and during placement. These factors and support mechanisms are shown in Figure 5.1, which might be said to represent the optimum or ideal situation for an ESL student on placement.



**Figure 5.1: Factors and support mechanisms to facilitate effective communication**

## 6 Conclusion

Undertaking tertiary study in a second language and in the context of an unfamiliar culture would be a daunting prospect for most people. Yet large numbers of ESL students successfully complete their programmes in New Zealand each year, overcoming many obstacles and challenges along the way. Their achievements are a testament to their tenacity, courage and sheer hard work, often in the face of considerable difficulties.

ESL nursing students face particular challenges because their programme includes a significant amount of clinical placement. Effective communication in English during this placement is a criterion for successful completion. While entry to the programme is usually dependent on a test of English language ability, these tests are often based on academic rather than practical requirements. The English required for the academic part of the programme is very different from the spoken English required for successful communication on placement. Academic English involves activities such as reading and writing academic texts or making formal presentations. There is time to practise, revise and correct work before submission. There are opportunities to work with your peers or friends, and there is time to access help from student support services, to ensure that your work is up to the mark.

In clinical placement, you are out in the real world, on your own, operating in real time. Interactions happen quickly, without time to prepare. You must communicate with a wide range of people for a wide variety of purposes, often under pressure. You must form working relationships with other staff members and therapeutic relationships with patients, and use the correct terminology and levels of formality. The consequences of misunderstanding or misinterpretation are high risk, involving not only academic failure, but also the safety of the patients in your care.

The findings of this study indicate there are several factors that support ESL students' mastery of the communication required for placement. These factors are the student's level of English language proficiency, the extent to



which the student is able to adopt the proactive approach that will enable full access to learning opportunities within the placement, and the choice of preceptor and placement setting. These factors need to be addressed if we are to provide students with the best chance of success.

## **6.1 Practical Implications**

English for effective communication in placement requires ability with both formal, technical forms of language and the informal, social language necessary to develop relationships with both patients and colleagues. This informal language requires a sophisticated use of the pragmatic skills of New Zealand English, so that the language used is appropriate to the purpose, audience and context. Native speakers of English develop these skills gradually, over many years, and may be unaware of the underlying rules governing appropriate language use.

The English language entry requirements to undergraduate nursing programmes may ensure that students have knowledge of the 'what' of language, or the organisational competence described by Bachman (1990): knowledge about the language, its forms and structures. Pragmatic competence, however, is also needed in order to communicate effectively as a health professional. Language acquisition models such as that proposed by Cummins (1983) suggest that every day, social use of English (what Cummins calls Basic Interpersonal Communication Skills, or BICS) develops naturally as ESL students interact with others at school or at work, and can be acquired through such means within the space of around two years. However, it is unrealistic to expect ESL students to develop the sophisticated pragmatic language skills required for placement merely through their experience in the academic programme. It is also unrealistic to expect them to develop these skills by living in a homestay situation, by interacting with Kiwi people, or by listening to Kiwi radio, although all these things are likely to help. Moreover, students may choose not to go into a homestay situation, for many justifiable reasons including high cost, previous negative

experiences, and a preference for living with those from a similar cultural background as an antidote to loneliness and emotional isolation.

ESL students have knowledge of the pragmatic rules of their own language but these do not automatically translate to English. Most Kiwis are naturally hesitant to comment on another's misuse of pragmatic rules which may manifest as apparent over-directness, abruptness or rudeness when interacting with others. So, until ESL students are in a 'high stakes' situation such as the transition to practice placement, where their language is being assessed in a professional capacity, they may not receive direct feedback about this aspect of their language use.

Explicit instruction is likely to speed up the development of pragmatic competence. Specifically, ESL students need direct instruction on the sociopragmatic rules governing appropriate language use in the clinical situation: how to chat with a staff member, how to ask a patient to do something uncomfortable, how to interrupt a surgeon, or how to clarify an instruction given by a senior staff member, for example.

As tertiary educators, we have a responsibility to provide students with the support they need to have a reasonable chance of success in their programme. In the case of nursing programmes, ESL students should be offered the experiences and support that will adequately prepare them for clinical placements, and the opportunities to develop the skills likely to facilitate success. This preparation should include explicit instruction and practice in the kinds of oral communication that will be required on placement, and in particular on the pragmatic rules of language use that govern appropriate use of language in this situation. This will require input from specialist language teachers as well as from nursing faculty.

Armed with the appropriate language skills, students need access to the interactions within the placement, in order to apply and practise these skills and to observe the communication of expert others. This access can be facilitated both by the student, through the exercise of personal agency, and by those within the placement, such as the preceptor and senior staff members.

Students who have a proactive, assertive learning style, and who are able to display initiative, are easier to accommodate in clinical placements. They make fewer demands on staff, and are able to negotiate their own learning experiences, by putting themselves forward to take up opportunities. Some ESL students may find themselves at odds with this approach and so be disadvantaged in clinical placements. Students need to be guided towards the most effective learning style, through direct instruction in the strategies that will enhance their ability to enter the practices of the community. This instruction should be structured as part of the programme of study.

Other staff members in the placement have a dramatic impact on the quality of the students' learning. A preceptor who is confident and comfortable working with an ESL student, and who has the skills to facilitate learning, can help the student to feel secure and confident in his or her developing abilities. Likewise, an environment where staff members are welcoming to ESL students and that displays an inclusive rather than discriminatory atmosphere, can do much to foster the confidence that is needed for a student to feel he or she is a legitimate member of the team. Placing ESL students with appropriate preceptors in supportive settings is an important consideration for tertiary nursing educators.

The data from this research have confirmed that ESL students in placement face and overcome considerable challenges in their quest to become registered nurses. For two of these students, these challenges were overcome only in the final weeks of their placement and thus of the undergraduate programme as a whole, by personal turnaround in response to direct feedback that they might be in a 'failing' situation. Tertiary educators have a clear role to play in supporting students and ensuring that they are well prepared for placement, and have developed the necessary communication skills and learning styles. Helping ESL nursing students to develop their confidence and agency as ESL communicators will also support their growing identity as legitimate members of the nursing community. These are important considerations for undergraduate nursing programmes and deserve careful attention.

# 7 Appendices

## 7.1 Student Interview Guides

### Interview Guide (1)

#### 1 Introduction

Who I am, purpose of the research: 'To help future ESL students have good experiences in clinical placements'.

- Use of tape recorder
- The information you give will be confidential
- There are no right or wrong answers
- You don't have to answer any questions that you don't want to
- You can ask to turn off the tape at any time
- Please tell what you think
- Do you have any questions before we begin?

#### 2 Biographical / background information

- What is your home country?
- How long have you lived in New Zealand?
- What is your native language?
- Do you speak any other languages?
- How old are you?

#### 3 Use of English / language acculturation

- Have you studied English, either in your own country or in New Zealand?
- Do you speak English outside of study, for example at home, or with friends?
- What kinds of things do you like to do outside of your study, for example to relax or on the weekends?

## 4 Motivation

- What interests you most about nursing?
- Have you worked in the health sector, either in your own country or in New Zealand?
- What do you hope to do once you have finished your degree?
- Tell me about something in your course that you have really enjoyed.
- Tell me about something in the course that has been difficult.

## 5 Clinical Placements

- Can you remember your first clinical placement? What was the hardest thing for you?
- Tell me what you are most looking forward to, in your Transition to Practice placement.
- What do you think will be the most difficult thing for you?
- *Exercise – how do you feel about communicating?*
- *Exercise – aspects of spoken language use*
- Who do you go to if you need help with communication in placement?

## 6 Conclusion

- What has been the biggest help for you, in learning to communicate in practice?
- If you could ask for one thing to help you with communication in placement, what would it be?
- If you had to help a new, first-year student from your own country to prepare for clinical placement, what would your best piece of advice be?
- Are there any more things you would want to say before we end the interview?

## Interview Guide (2)

### 1 Introduction

- As for Interview 1

### 2 Placement experience

- Tell me about your placement.
  - What is going well?
  - What are you finding most difficult?
- Last time, you were concerned about \_\_\_\_\_. How is that going?

### 3 Communication on placement

*How do you feel about communicating exercise*

- Tell me about speaking with patients (including listening).  
*Prompt: commands (asking clients to do things) / social talk / explaining procedures / health history*
  - Has there been a time when you have felt really good about your communication with patients?
  - What about a time when you felt you could have communicated better?
- Tell me about speaking with your buddy nurse / preceptor  
*Prompt: asking questions / clarifying*
- Tell me about speaking with other staff on the ward – nurses, etc.  
*Prompt: social talk, asking questions*
- Tell me about speaking with other health professionals  
*Prompt: answering telephone, reporting*

## **4 Conclusion**

- If you could improve one area of your communication, to help you with your placement, what would it be?

Prompt: Why is that so important?

## **Interview Guide (3)**

### **1 Introduction**

- As for interviews 1 and 2.

### **2 Placement experience**

- Tell me about your placement.
  - Tell me about something that you really enjoyed.
  - Tell me about something that you found difficult.
- If you could change one thing about your placement, what would it be?

### **3 Communication**

- Tell me about communication in placement.
  - What aspect of communication went well?
  - What aspect of communication was difficult
  - What feedback did you get from your preceptor and clinical lecturer about your communication?

*How do you feel about communicating exercise*

*Aspects of spoken language use exercise*

### **4 Looking to the future**

- Now that you have finished your placement, what are your plans?
- What help would you like, with communication skills, for your future practice?

### **5 Conclusion**

- What advice would you give an international student, about communicating in placement?
- Are there any more things you want to say before we end the interview?



## **6 Future arrangements**

- Keeping in touch
- How can I contact you to give you the results of the study?

## **7.2 Lecturers' Focus Group Guide**

### **1 Introduction**

- Introductions, purpose of the research
- Use of tape recorder
- The information you give will be confidential
- Do you have any questions before we begin?
- Consent forms

### **2 Focus group questions**

In your experience of working with students in clinical placements:

- What are the main challenges facing English-as-a-second-language (ESL) students in clinical placements?
- What difficulties do ESL students have in communicating with clients and other staff in the clinical setting?
- What could be done, prior to placement, to help ensure that ESL students have the necessary communication skills for the clinical setting?

### **3 Aspects of spoken language use exercise**

How important to communication in clinical are the following?

Rank the cards in order of importance.

## **7.3 Preceptor Interview Guide**

### **1 Introduction**

- Introductions, purpose of research
- Use of tape recorder
- The information you give will be confidential
- Do you have any questions before we begin?
- Consent forms

### **2 Interview questions**

- Tell me about the preceptor role.  
Prompt: training, number of students worked with
- Have you worked with any other students with English as a Second Language?
- In your view, what difficulties do ESL students have in communicating with clients and other staff in the clinical setting?
- What could be done, prior to placement, to help ensure that ESL students have the necessary communication skills for the clinical setting?

### **3 Aspects of spoken language use exercise**

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