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**Communication in Clinical  
Practice:  
Critical success factors for ESL  
students**

A thesis completed in fulfilment of the requirements for the  
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# Abstract

This study investigates the factors most likely to support effective communication in clinical placements for ESL nursing students in New Zealand. The experiences of ESL students as they complete a clinical placement are examined and compared with data from the students' clinical lecturers and preceptors.

Data for the study was collected through interviews with individual students before, during and after their Transition to Practice placement. Interviews were also held with two of the students' preceptors, and a focus group was held with clinical lecturers who had experience of working with ESL students. Results from the study underline the importance of facilitating students' entry to the placement community of practice, and access to its interactions. A number of factors supported or inhibited students' participation and learning within the placement community.

The study identified two critical factors intrinsic to the student, and two extrinsic to the student. Intrinsic factors included the student's proficiency with English language: in particular, the sophisticated sociopragmatic language skills used by nurses in their daily interactions. The student's use of learning strategies, including the proactive approach best suited to learning on placement, was also critical. Extrinsic factors likely to support the student's integration within the community of practice were the quality of

the preceptor, in terms of attitude to and training for the preceptoring role, and the tone of the placement environment.

The major outcomes of this study point to the importance of providing direct instruction for ESL students in the kinds of language and learning styles required for placement. There are also implications for the selection and training of preceptors and for the placing of students in appropriate clinical environments. The study concludes with suggestions for a specific communication programme for ESL students.

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# Table of Contents

<b>1</b>	<b>INTRODUCTION.....</b>	<b>1</b>
1.1	Background .....	1
1.2	Nursing Training in New Zealand .....	3
1.3	The Research Topic .....	7
<b>2</b>	<b>LITERATURE REVIEW.....</b>	<b>9</b>
2.1	Competent Communication in a Second Language .....	10
2.2	Pragmatic Language Skills in the Nursing Workplace .....	13
2.3	How Do Nurses Learn Communication Skills? .....	18
2.3.1	Communication skills in undergraduate nursing programmes .....	19
2.3.2	Learning communication skills through clinical placements .....	19
2.3.3	Second language learning in clinical placements .....	22
2.4	What are the Communication Problems for ESL Nurses? .....	25
2.5	Helping ESL Students Acquire Communication Skills for Clinical Placement.....	28
2.5.1	ESL programmes on workplace communication .....	28
2.5.2	ESL programmes on communication for clinical placements.....	31
2.5.3	Summary.....	32
<b>3</b>	<b>METHODOLOGY.....</b>	<b>34</b>
3.1	Introduction .....	34
3.2	The Research Approach .....	35
3.3	The Research Process: Students .....	38
3.3.1	Recruitment and selection of students .....	38
3.3.2	Characteristics of students .....	39
3.3.3	Pilot study .....	40
3.3.4	Student interviews.....	41
3.3.5	Emails on placement.....	48

3.4	The Research Process: Clinical Lecturers .....	48
3.4.1	Focus group .....	49
3.5	The Research Process: Preceptors .....	50
3.5.1	Recruitment and selection of preceptors.....	50
3.6	Data Analysis.....	53
<b>4</b>	<b>RESULTS: FINDING A VOICE.....</b>	<b>55</b>
4.1	Intrinsic Factors: English language proficiency .....	57
4.1.1	Express ideas clearly, confidently and appropriately .....	60
4.1.2	Engage in and maintain conversations .....	65
4.1.3	Pronounce clearly .....	68
4.1.4	Comprehend others' speech .....	70
4.1.5	Understand Kiwi/New Zealand English.....	73
4.1.6	Use medical terminology correctly.....	74
4.1.7	Pressure points .....	76
4.2	Intrinsic Factors: Proactive approach to learning .....	82
4.2.1	Asking questions .....	83
4.2.2	Seeking and responding to feedback.....	84
4.2.3	Acting assertively.....	85
4.2.4	Identifying as a nursing student .....	86
4.3	Extrinsic Factors: Effective preceptor .....	88
4.3.1	The role of the preceptor .....	88
4.3.2	Student perceptions of 'good' preceptors .....	89
4.4	Extrinsic Factors: Supportive environment.....	94
4.4.1	Discrimination in placements .....	94
4.4.2	Supportive environments .....	97
<b>5</b>	<b>RESULTS: THE PATH TO CONFIDENCE .....</b>	<b>100</b>
5.1	Group One: Two steps forward, one step back .....	103
5.2	Group Two: Full steam ahead .....	107
5.3	Supporting Students in Placement .....	109

5.4	Conclusion.....	111
<b>6</b>	<b>DISCUSSION AND IMPLICATIONS.....</b>	<b>113</b>
6.1	Question One: .....	113
6.1.1	Intrinsic factors: English language proficiency.....	113
6.1.2	Intrinsic factors: Proactive approach to learning .....	117
6.1.3	Extrinsic factors: Effective preceptor.....	118
6.1.4	Extrinsic factors: Supportive environment .....	119
6.1.5	The role of confidence.....	120
6.2	Question Two:.....	123
6.2.1	Specific instruction in the language and communication required for placement .....	124
6.2.2	Proactive approach to learning .....	128
6.2.3	Matching ESL students with supportive preceptors and colleagues.....	128
6.2.4	Fostering an inclusive atmosphere throughout the programme .....	129
6.3	The Optimum Situation.....	130
<b>7</b>	<b>CONCLUSION.....</b>	<b>133</b>
7.1	Practical Implications .....	134
	<b>APPENDICES.....</b>	<b>138</b>
	<b>BIBLIOGRAPHY.....</b>	<b>161</b>



# List of Appendices

1	Student invitation to participate .....	138
2	Student information sheet .....	140
3	Student consent form .....	143
4	Student interview guide (1) .....	144
5	Student interview guide (2) .....	146
6	Student interview guide (3) .....	148
7	Language acculturation exercise .....	150
8	Clinical lecturers' information sheet .....	151
9	Clinical lecturers' consent form .....	154
10	Clinical lecturers' focus group topic guide .....	155
11	Preceptors' invitation and information sheet .....	156
12	Preceptors' interview guide .....	159
13	Preceptors' consent form .....	160

# List of Tables and Figures

1.1	Interpersonal interactions, inferred from Competencies for the Registered Nurse Scope of Practice (NCNZ, 2007)	5
2.1	Interpersonal interactions, inferred from Competencies for the Registered Nurse Scope of Practice (NCNZ, 2007)	11
2.2	Bachman’s model of ‘language competence’	13
3.1	Background and characteristics of the students	41
3.2	Example of completed Confidence in Communicating exercise	44
3.3	Aspects of spoken language use exercise	45
3.4	Example of ‘aspects of spoken language use’ exercise	46
3.5	The data collection timeline	52
4.1	Factors influencing the development of competent communication on placement	56
4.2	Language proficiency factors ranked by importance	58
4.3	Elements of ‘good’ English for communication in placement	60
4.4	Pressure points for communication	77
4.5	Pages from a ‘Health History’ form	79
4.6	Summary of language demands on placement	81
4.7	Qualities of a ‘good’ preceptor as perceived by students	89
4.8	Relationship between confidence, interaction and communication: positive cycle	98
5.1	Confidence in communicating, as reported at each student interview	101
5.2	Paths to confidence in communicating in placement	102
5.3	Group one: predicted difficulties in placement	103
5.4	Group one: actual difficulties in placement	106
5.5	Group two: predicted difficulties in placement	107
5.6	Group two: actual difficulties in placement	109
5.7	Participants’ suggestions for ESL student support	110
6.1	Factors and support mechanisms to facilitate effective communication	132



# Chapter One

## Introduction

### 1.1 Background

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 the population as a whole brings with it the need for a matching diversity of health-care professionals, 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 health-care 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 on matters such as academic quality, curriculum design, and assessment practices. Before taking on this role, I worked as a teacher, including teaching English as a second language in the adult and tertiary education sectors. Consequently, I have a keen interest in tertiary students for whom English is a second language (ESL students), and in their experiences within the polytechnic's programmes.

Over recent years, programmes within the School of Nursing at the polytechnic have experienced increased enrolments of ESL students. During 2007, several academic staff in the School expressed concerns about these students' needs and experiences in the programme. These concerns often came 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 brought a unique set of challenges that could prove overwhelming. In some cases, these challenges caused students who had so far successfully completed their papers to fail or withdraw from the programme.

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 achieving an effective level of communication, due to inadequate English language proficiency, was often cited as the main obstacle to a successful placement outcome for ESL students. However, informal discussions with a range of staff and

students suggested that other factors, such as discrimination or cultural misunderstandings, might also play a significant part.

Students' experiences in the clinical placements are likely to affect their perception of themselves as future health-care workers, and their motivation for future study. I believe it is vitally important for nursing educators to identify and put in place the supports that are most likely to equip ESL students for successful placements, especially in terms of appropriate communication skills. In this way, we will not only support our students to succeed in their chosen programme, thereby also increasing our retention and successful completion rates, but we will also encourage the diversity in our healthcare workforce that will enable us to meet the needs of the rich mix of cultures within the New Zealand population.

## **1.2 Nursing Training in New Zealand**

Communication is an essential skill for effective nursing. Nurses must communicate with a wide range of people, for a variety of purposes, in order to ensure the best outcomes for clients within their care.

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. The 'Competencies for registered nurses' (NCNZ, 2007) fall under four domains:

- Domain one - professional responsibility
- Domain two - management of nursing care
- Domain three - interpersonal relationships
- Domain four - interprofessional health care and quality improvement.

Domain three, interpersonal relationships, includes the competency that 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 19 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 below).

Being able to engage effectively in these communicative activities could therefore be considered to represent competency in communication for registered nurses, or as Hymes (1967, 1972, as cited in Brown, 2000) puts it, the ability "to convey and interpret

messages and to negotiate meanings interpersonally within specific contexts' (Brown, 2000, p. 246).

**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 interest</li> <li>• Establish rapport and trust</li> </ul>	<ul style="list-style-type: none"> <li>• Client</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>• Health care team</li> </ul>

The Nursing Council of New Zealand specifies the content that must be included in the curricula for undergraduate nursing programmes. Each curriculum must include content on "therapeutic communication skills" (NCNZ, 2005, p5): communication that is designed to promote



healing and change and that will have a positive impact on the client's overall wellbeing (Wachtel, 1993). There is no requirement for content on the more general interpersonal communication skills that are part of a nurse's role, although individual providers might choose to cover these as part of other specified content such as "professional nursing practice".

Undergraduate nursing programmes use a variety of methods to teach the communication skills required for placement, with varying degrees of effectiveness (Chant, Jenkinson, Randle, Russell & Webb, 2002). Content, time allocated and assessment methods for communication skills teaching vary significantly between programmes (Chant et al., 2002).

Clinical practice hours allow 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 in a 'real' environment such as a hospital or clinic, gradually taking on responsibility in a structured way. 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 and provides overall supervision for the placement experience. While on placement, students are expected to display a proactive attitude, actively seeking and initiating clinical learning opportunities (NETS/NENZ, 2007a). 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 the clinical lecturers, and is based on progress towards the competencies for the registered nurse scope of practice.

### **1.3 The Research Topic**

This research was designed to provide greater understanding of the factors that influence ESL students' ability to communicate effectively in the clinical setting. The intention is 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.

The interaction between factors operating in each placement experience will be explored. While each student's placement experience is unique, the result of the interaction between the student, the placement and the preceptor, nevertheless there are areas of similarity. The characteristics of the various factors operating in each situation, and the way these work on each other, contribute to the student's developing competency in communication. The optimum mix of factors to facilitate a student's journey to effective communication for the placement will be discussed, with ideas on how this mix might be created for individual students.

Perceptions and attitudes towards English language proficiency, and its relationship to effective communication as a health professional,

will also be examined. 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, and what does it look like? How can we, as educators, support ESL students to become confident and effective members of the New Zealand health-care profession? This study is designed to explore these questions.

# Chapter Two

## Literature Review

In this chapter, literature relevant to the research topic will be reviewed.

The chapter begins by exploring models of competent communication and the factors involved in language proficiency. The concept of pragmatic competence, including sociolinguistic skills, is explored and applied firstly to the New Zealand workplace, and then to communication in the clinical setting in particular. A study that analysed recordings of language used by nurses in their daily work is used to inform this section.

The second part of the chapter explores the ways in which student nurses acquire skills in effective communication for clinical placements. This may be through structured tuition within undergraduate nursing programmes, or through learning 'on the job' while on placement. Models of workplace learning, including the concept of a 'community of practice', are reviewed and applied to clinical placements.

Finally, research on communication programmes for ESL students is explored. Two examples of successful communication programmes designed specifically for ESL nursing students are described, and their main characteristics and approaches are summarised.

## 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 of communicative competence 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. Competent communication requires active participation by both producer and receiver, it is dynamic, and it is influenced by and bound by the particular context and purpose for the communication.

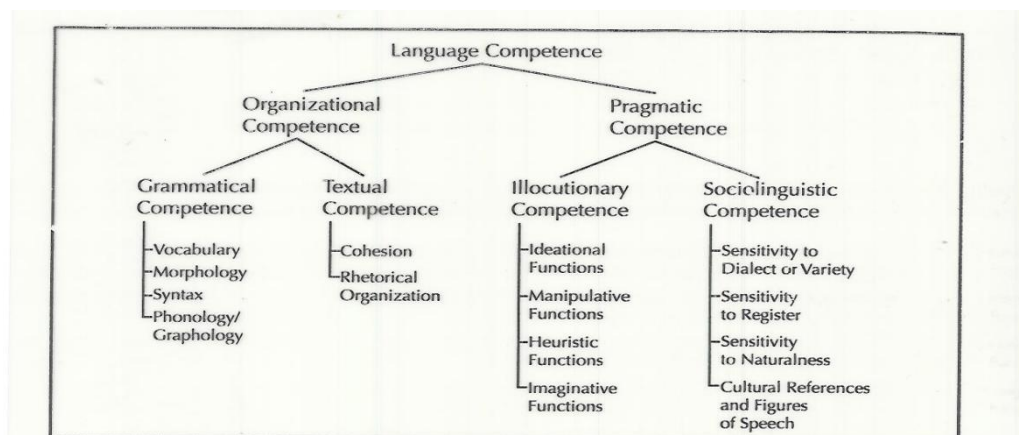
In recent times, sociolinguists interested in the social functions of and influences on language have proposed models of competent communication that emphasise the importance of social and contextual factors. These models provide a useful framework for exploring the factors involved in communicating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

Canale and Swain (1980) defined communicative competence with reference to four essential components:

- **Grammatical competence**, which involves knowledge of the rules of language, such as grammar and vocabulary.
- **Discourse competence**, which involves knowledge of the way in which stretches of language are connected to provide meaning, by means of features such as coherence and cohesion.
- **Sociolinguistic competence**, which involves knowledge of the social context and culture in which communication takes place, so that language is used appropriately to the given situation.

- **Strategic competence**, which involves use of communicative strategies such as paraphrasing or asking for repetition to compensate for any breakdown in communication, or to enhance the communication.

The first two of these components, grammatical and discourse competence, 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 model of ‘language competence’**

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

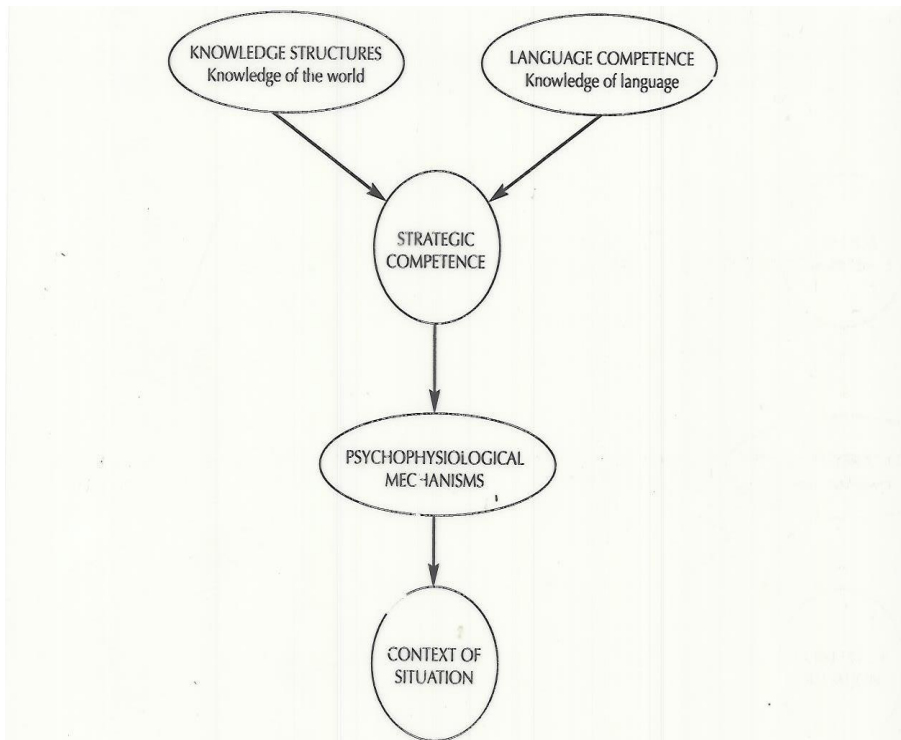
- **Organisational competence**, which is concerned with the formal features or rules of language (further divided into grammatical competence and textual competence, aligning with Canale and Swain’s grammatical and discourse competence);
- **Pragmatic competence**, which is concerned with how language 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.

In Bachman's model, **strategic competence** has a pivotal role in developing competency in communication. It is the filter through which both language competence and knowledge of the world pass, in order to make a final decision on how best to achieve a particular act of communication (see Figure 2.2).

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.



**Figure 2.2: Bachman's model of communicative language ability in communicative language use (Bachman, 1990, p. 85)**

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

Clinical placements are essentially work placements. Students work alongside an experienced nurse (a 'preceptor'), gradually taking on more responsibility and being initiated into the role of a registered nurse in the clinical environment.

In order to be effective within the nursing workplace, students must have a clear understanding of the role of the nurse in New Zealand. This understanding includes knowledge about the types of communication required of a registered nurse. That is, not only knowledge of appropriate medical and nursing language and vocabulary, but also knowledge about interpersonal communication skills. These skills are vitally important to a nurse's work both with other team members and with clients. While technical, medical language and therapeutic communication skills for use with clients



are usually taught as components of the nursing programme, general interpersonal communication skills suitable for the clinical workplace may receive less attention, or be assumed to be part of each student's background knowledge. However, workplace language and conventions are often culturally bound, and ESL students with different cultural references may require specific instruction in order to master them. For example, while friendly small talk is an important aspect of establishing relations in the New Zealand workplace, migrants from other cultures might interpret it as overly intrusive or as inappropriate in a professional context (Clyne, 1994, as cited in Holmes & Riddiford, 2009). Research (for example Holmes, 2005) suggests that students who do not understand the language conventions of the workplace may have difficulty 'fitting in' and achieving acceptance.

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 the workplace. 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. Knowledge of these skills develops gradually over a long period of time; for native speakers this occurs naturally as part of the 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 has this experience and exposure. (p. 350)

Native speakers may be unaware of the underlying rules and conventions governing appropriate language use, 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 a bald imperative such as “Raise your arm”. Such a direct request might be interpreted as impolite (Holmes & Major, 2003). It is much more acceptable to use a range of softening and hedging devices to make the instruction less direct, as in the example, “Could you just raise your arm for me, please”.

Native speakers are able to draw on their innate 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 their lack 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. Holmes and Major’s 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 the 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.

A later study by Dowell, Macdonald, Stubbe, Plumridge and Dew (2007) analysed consultations between General Practitioners and patients. The authors found that the first 30 seconds of each interaction was crucial: within this period, participants assessed each other and tailored their interaction accordingly, applying sociolinguistic knowledge to choose appropriate language strategies. The interactions themselves were complex, as the health practitioners juggled professional, institutional, relational and practical demands and goals. This demanded a sophisticated set of language skills and resulted in talk that might appear to be "messy and imprecise" (p 348), as is the case with most social interactions where "we often do not talk in complete sentences" (p. 348). While this study concerned doctors rather than nurses, it confirms the findings of Holmes and Major (2003); that is, that forming effective relationships with patients involves skilful use of sociolinguistic

strategies, often under pressure of time, and requires an expert balance between interpersonal and transactional interaction.

'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. In this context, being able to 'chat' appropriately is made more complex for nurses as their patients may be uncomfortable, in pain, affected by medication, or have hearing impairments or speech difficulties. Because of these factors, patients may also have limited ability to cope with unfamiliar patterns of speech, for example from nursing staff who speak English as a second language.

The next section of this chapter will look at how the important skills of interpersonal communication, informal social talk and sociolinguistic and pragmatic competence are taught and learnt.

## **2.3 How Do Nurses Learn Communication Skills?**

There are two main formal avenues by which student nurses learn effective communication skills for the clinical setting: the structured teaching of communication as part of an undergraduate nursing programme, and learning 'on the job' within clinical placements.

### **2.3.1 Communication skills in undergraduate nursing programmes**

The communication skills that nurses require in order to be effective in the workplace cover a wide range of interactive styles, involving different registers. Besides the more formal types of communication such as reporting at the beginning and end of shifts, students must also be able to communicate informally, for example to engage in small talk with clients. As noted in section 1.2 above, the Nursing Council of New Zealand specifies that undergraduate nursing programmes must prepare students to communicate effectively with clients and members of the health care team, and that programmes must include content on therapeutic communication skills. However, as Chant et al. (2002) point out, the method by which communication skills are taught, the amount of time allocated to them, and the effectiveness of the methods used varies widely from programme to programme.

### **2.3.2 Learning communication skills through clinical placements**

The clinical placement is a workplace learning environment, and shares some of the features of an apprenticeship. Students apply and practise skills learnt in the classroom and develop competence by working alongside experienced practitioners.

Studies of workplace learning emphasise that learning in these settings occurs in a social context (for example Billett, 2001). 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).

In a study based on the experiences and perceptions of undergraduate nursing students relating to their clinical placements, Andrews, Brodie, Andrews, Hillan, Thomas, Wong and Rixon (2006) identified several key factors related to a positive placement experience. Among the most critical of these factors were the quality of the ward manager's leadership and the quality of the mentoring provided by the designated nurse supervisor (or 'preceptor'). The ward manager was critical in setting the 'tone' of the placement, establishing a "facilitative, conducive learning environment" (p. 865) and enhancing "the acceptance of students in clinical places as essential team members" (p. 866). Mentors had a vital role to play in facilitating and supporting students' learning, but many were unprepared for their role, and had not received specific training. Students' preparation for the placement, specifically in terms of their learning styles, also played an important part in the quality of their experience. The majority of students had "an expectation of passive learning, being taught by others ... rather than actively seeking knowledge and skills themselves" (p. 869). As students with active learning styles, who are self-directed and able to act assertively, may be better placed to negotiate access to relevant learning opportunities, Andrews et al. conclude that explicit instruction in active learning strategies may be required as preparation for placements.

### **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 coparticipation", where "Learning is an integral and inseparable

aspect of social practice” (p. 31) and occurs when members engage with and participate in that practice.

Newcomers to a particular community of practice become integrated with that community through a process of “legitimate peripheral participation” (Lave & Wenger, 1991, p. 14). This is akin to an apprenticeship model, where learners engage in the practice of the community, but at first to a limited extent and with limited responsibility. 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 them 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:

As a place in which one moves toward more-intensive participation, peripherality is an empowering position. As a place in which one is kept from participating more fully – often legitimately, from the broader perspective of society at large – it is a disempowering position. (p. 36)

From this disempowered position, the newcomer can become marginalised, resulting in a lack of access to the practices of the community that will adversely affect learning. As learners gradually enter into the community, and become familiar with and competent in its practices, they begin to take on a new identity as a legitimate member of the community. This identity can be threatened if access to the community is blocked and learners are marginalised: “In practice, we know who we are by what is familiar, understandable, usable, negotiable; we know who we are not by what is foreign, opaque, unwieldy, unproductive” (Wenger, 1998, p. 153). Becoming competent and fluent in a particular community or setting is therefore closely aligned with identity.



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. If the student is not able or willing to engage in the community, or if access to the community's practice is blocked, learning will be curtailed: "Without this engagement, there is no learning" (p. 24). Engagement in the practice of the community is an essential component of mastering its 'discourse'; that is, "ways of using language that can be used to identify oneself as a member of a socially meaningful group" (Gee, 1996, p. 130). Becoming competent in the communicative patterns of the practice community is therefore allied to students' growing self-identity as members of the nursing profession.

### **2.3.3 Second language learning in clinical placements**

A large body of second language learning research points to the characteristics of individual learners as powerful indicators of their success in language learning. Characteristics such as motivation, learning style and personality traits have all been identified as possible predictors of language-learning success (for example Naiman, Frolich, Stern & Todesco, 1995; Gardner, 1985; Reid, 1995; Guiora, Beit-Hallahami, Brannon, Dull & Scovel, 1972). More recently, researchers have focused on the social aspects of language learning, and the sociocultural factors that may influence learners' acquisition of language (Pavlenko & Lantolf, 2000; Pennycook, 2001).

Sociocultural language-learning theory suggests that the focus needs to move away from individuals and their characteristics, and instead look to the social communities in which language learning takes place, and how these settings affect learning. According to these theories (and also aligning with Lave and Wenger's community of practice model), language learning occurs as students become increasingly involved in the practices of a particular community, including its interactions.

Duff (1996, cited in Roberts, 2001) proposed a model of second language socialisation (SLS). This model takes a holistic view, examining the social forces and norms operating within a particular context and the way these affect language use and language learning. Roberts sees SLS as an apprenticeship model: "The learner over time participates in the interactional life of the new community and is gradually inducted into what are taken to be its pre-existing discourses. This model implies a 'learning by doing' approach" (p.113). SLS therefore aligns closely with Lave and Wenger's model of learning by legitimate peripheral participation in a community of practice.

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 a dynamic concept, and the form it takes is influenced by the situation and circumstances surrounding the individual: agency is "never a 'property' of a particular individual; rather, it is a relationship that is

constantly co-constructed and renegotiated with those around the individual and with the society at large” (Lantolf & Pavlenko, 2001, p. 148). 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.

Two of the successful language learners studied by Toohey and Norton were Eva (an adult) and Julie (a child). Both these learners exercised personal agency in negotiating access to social interactions within their communities. Eva negotiated access to the social interactions within her workplace by taking part in out-of-work social activities with her workmates and partner. By this means, she was able to renegotiate her identity within the workplace from immigrant worker to a person whose identity was respected and whose company was valued and sought after. From this position, she was able to gain access to interactions that enabled her to fully enter the community and learn its practices, including language use. Likewise, Julie was able to position herself as a ‘good’, well behaved member of her kindergarten class, with allies among the other children. These allies would help to facilitate her access to play materials and thus interactions with other members of the kindergarten community. Toohey and Norton conclude that both studies “demonstrate that access to second language networks, and increasing participation in them, is coincident with second language learning” (p. 71). In agreement with Lave and Wenger (1991) and Wenger (1998), they conclude that “learning to use the tool of language, like learning to use the tools of other activities, is primarily a matter of access to skilled performance, practice and access to identities of competence” (p. 71).

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. This preparation might include direct instruction in learning strategies that will support the proactive approach underlying the concept of personal agency.

This section has provided an overview of ways in which the communication skills for clinical practice may be learnt. The following section will provide an overview of the research on ESL nursing students and communication, focusing specifically on problematic aspects of communication.

## **2.4 What are the Communication Problems for ESL Nurses?**

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). This anxiety is compounded by students' recognition that fluency is of great importance in the clinical setting. Language anxiety, particularly "apprehension arising from learners' inability to express mature thoughts and ideas" and "fear of negative social evaluation, arising from a learner's need to make a positive ... impression on others" (Brown, 2000, p. 151) is likely to have a negative impact on further language learning. Anxiety has been linked to a weakened sense of self-efficacy or personal competence, which in turn is likely to affect students' willingness to communicate (MacIntyre & Gardner, 1991, cited in Brown, 2000, p. 151; Mills, Pajares & Herron, 2006; MacIntyre, Dornyei, Clement, & Noels, 1998). 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.

In an effort to identify problematic areas of communication for ESL health professionals, linguists Wette and Basturkmen (2006) examined videotapes of roleplay sessions in which overseas-trained doctors interacted with patients. The doctors had all been assessed as having advanced English language skills, scoring an average of at least 7 on the International English Language Testing System (IELTS). However, Wette and Basturkmen found that the students commonly required assistance to communicate in ways that would help create an empathic relationship with clients. Such communication requires sophisticated and subtle use of language and would be best achieved through "explicit and sustained English language instruction" (Wette & Basturkmen, 2006, p. 64):

Creating and maintaining an empathic relationship in the cultures of English-speaking countries in fact involves not

only cultural knowledge in this area, but also a sophisticated use of language ... mastery of informal register and lay-medical terms, of minimal responses that are also empathic and non-judgemental, of qualifiers and of a variety of speech acts. (p. 73)

Wette and Basturkmen's study adds weight to the need for explicit instruction for second language students in sociolinguistics and the pragmatic patterns of New Zealand English, as signalled by Holmes and Major (2003), Holmes (2005), Riddiford and Joe (2005) and others. In a report on a support initiative to improve the outcomes for ESL students on clinical placement at the University of South Australia, Hussin (2009) suggests that direct teaching of relevant aspects of sociolinguistics would positively impact on nursing students' placement outcomes:

Many ESL students do not automatically pick up the finer points of communication behaviour simply by being exposed to them. This is because such students are culturally excluded by a lack of sociocultural knowledge underpinning the rules of sociolinguistic behaviour in a Western culture. To be successful in their placement, students often need overt instruction in areas of sociolinguistics. (p. 364)

Knowledge of the dominant culture of the health care system can also affect students' ability to communicate effectively. This Western, Anglo-Celtic culture may be at odds with students' own culture and values, including those influencing norms of communicative interactions (Bosher & Smalkoski, 2002; Shakya & Horsfall, 2000).

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 Helping ESL Students Acquire Communication Skills for Clinical Placement**

### **2.5.1 ESL programmes on workplace communication**

Several authors have described workplace communication programmes for ESL students. Uvin (1996) described and contrasted two workplace English programmes. One was based on a 'traditional' approach, using a needs analysis to determine the content, and where the programme was designed without learner participation. Uvin found that learner 'buy in' to the programme was limited, and attendance was patchy. While learners did make language gains, these were not maintained. The second programme was based on a participatory approach, where learners helped to decide what was to be taught and what methods would be used. Learners selected examples of interactions from their experiences in workplaces as the basis for exploration and discussion of language issues, through a problem-posing, experiential approach. This ensured that learning was meaningful and focused, as it was based on real-life examples of problematic interactions. The result was a gain in self-confidence and motivation, as well as improved language skills:

Learners ... became better language users and learners as they participated actively in the investigation of contexts where they needed English most and identified all the factors that shaped them.  
(p. 52)

This suggests that learning that is based on students' lived experiences and on content that is meaningful and of direct relevance may result in better and more sustainable language gains.

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 practising strategies via 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 study was based on the above programme (which had been developed and refined since the original pilot) and involved three intakes of students. The instruction module was made up of four components:

1. *Analysis of authentic conversations.* Examples of real-life communicative acts, including requests, refusals, complaints, suggestions and disagreements, from the data collected by the Language in the Workplace Project, Victoria University of Wellington were used to draw learners' attention to sociocultural factors such as familiarity, status and degree of difficulty in each situation, and how these influenced the communication (*noticing*).
2. *Discussion of L1 and L2 perception of the sociocultural factors involved.* This stage involved 'understanding' the



target features, through teacher-led exploration (*understanding*).

3. *Opportunities to practise the target language.* Role plays with classmates and native speakers were used as practice opportunities. The role plays were recorded and used for later analysis and reflection (*practising*).
4. *Observation.* Learners then observed instances of the target language as they went about their daily lives, outside the classroom and during work experience.

Discourse completions tasks, video-recorded role plays and retrospective interviews were used to examine the effect of this explicit instruction on students' development of sociopragmatic ability. 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.

Riddiford also refers to the struggle second language learners may face when engaged in social conversation in 'real time' (p. 90). Because of limited language resources, learners' attention is often focused on the meaning-making aspect of the conversation, rather than on pragmatic features. In such situations, the use of routinised 'chunks' of language (for example, 'I wonder if you could ...' as a general introduction for a request) can take the pressure off students, allowing them more time to focus on appropriate language choices for the situation.

## **2.5.2 ESL programmes on communication for clinical placements**

Two recent Australian initiatives are of particular interest to the present study. Both involved programmes designed specifically to support ESL nursing students to develop the communication skills 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. Students who were identified during their first placement as needing help with interpersonal communication skills were invited to attend the programme. Commercial teaching videos of nurse-patient interaction, and role play 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).

The research confirms that programmes designed specifically for ESL students can help these students develop the communication skills required for clinical placement. These programmes are more likely to be successful when they are based on authentic data, use students' own experiences, and provide opportunities to notice, explore and practise relevant aspects of language in a safe and supportive environment.

### **2.5.3 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.

The present study was designed to provide further information on the factors likely to lead to successful communication for ESL students on clinical placement. By focusing on authentic data gained from a range of students completing a clinical placement, I hoped to build a more detailed picture of factors affecting the students' outcomes. In particular, I wanted to investigate 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?

# Chapter Three

## Methodology

This chapter provides an overview of the planning, development and implementation of the research project. It begins with a short summary of the stimulus for the study. The three groups of participants, the research approach and the data collection methods are then outlined. Finally, the process used to analyse the data is described.

### 3.1 Introduction

As outlined in section 1.1, my work in a North Island polytechnic led to an interest in the challenges ESL nursing students face when on clinical placement, particularly in the area of communication.

To clarify the issues involved, and to confirm that this was a suitable area for research, I consulted with a range of people, from within and outside the polytechnic, over a period of several weeks towards the end of the academic year 2007. Those consulted included the Dean of Faculty, the Director of Nursing Education, student support services staff, lecturing staff (from both my own and other polytechnics), and international student coordinators. I also attended conversation and study groups for ESL students, in order to collect students' views on this topic. All these groups agreed that clinical placements could be problematic for ESL students, that communication skills in this setting were a major source of difficulty, and that research in this area would be useful, particularly if it could improve student outcomes.

I therefore began the process of planning how best to collect information from the major groups involved in the students' clinical placements: the students, their clinical lecturers and the preceptors.

### **3.2 The Research Approach**

I decided to use a qualitative approach for the study. 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, I hoped, provide insights into their experiences and subjective understandings. From these discussions, themes and patterns would emerge (Holliday, 2007).

This approach is informed by grounded theory methodology, in which the research generates theory through the analysis and interpretation of data collected from a variety of sources, including participants (Charmaz, 2006). It also shares some of the characteristics of case study research, as in-depth descriptions and analyses would be made of a number of students' experiences of a placement occurring at a particular point in their programme (Cresswell, 2007; Yin, 1994). From these descriptions and analyses, I would "attempt to identify the various interactive processes at work" in students' experiences of communication in placement (Bell, 2005, p. 10).

When describing the differences between the quantitative and qualitative approaches, Holliday points to the complex, 'messy'

nature of real-world research contexts, and the increasing trend for researchers to tell the research story “as it really happened” (2007, p. 7). The remainder of this chapter tells the story of this research project.

In order to build a complex picture of the experience of clinical placement, I wanted to find out about and compare the experiences of all three major groups of participants: students, clinical lecturing staff, and preceptors. This would hopefully provide rich data and enable me to compare perceptions of the situation. 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.

I planned to track the experiences of students moving through a particular 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 would be supplemented by a weekly email exchange during the course of the placement.

I also planned to interview each student’s preceptor: the registered nurse who was assigned to work alongside and ‘buddy’ the student during the placement. The interviews would be held on completion of the placement, so as to collect data on the preceptor’s perspective of the placement experience.

Finally, clinical lecturers who had worked with ESL students on placement would be invited to attend a focus group. A focus group would allow discussion and comparison of experiences between participants (Barbour, 2007). This would provide further valuable data and another perspective on the challenges ESL students might face in clinical placements.

In order to compare experiences across undergraduate nursing programmes and allow results to be generalised across a wider population, I planned to track students from both my own and a partner institution, as they completed a similar placement. A polytechnic within reasonable geographic reach was selected, and initial contact with staff in the Bachelor of Nursing programme there proved positive. I planned to interview eight students altogether: four from each institution. Eight students would provide a reasonable but manageable sample and also meant the study would still be viable should one or two students choose to drop out. Preceptors would be interviewed at each location, and two separate clinical lecturer focus groups would be held, one at each polytechnic.

Discussions with lecturing staff from both polytechnics 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 has a wealth of experience of clinical placements, and would be able to reflect back on these as well as on the current placement. In addition, 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 consider the cost/benefit ratio (Cohen, Manion & Morrison, 2007, p.50). It did not seem that there was much potential for harm for those participating. Confidentiality would be maintained and I was confident that my experience in working with ESL students would enable me to provide a supportive environment during the interview process, where students would feel comfortable. 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 subsequently judged to be of 'low risk'. A low risk notification was submitted to Massey University Human Ethics Committee, and I received confirmation from the Committee that the project had been recorded on the Low Risk Database.

The research proposal was then forwarded to the Research Committees of the two polytechnics. While approval was received from my own polytechnic's Research Committee, it was withheld by the partner polytechnic. Subsequent recruitment of participants and data collection therefore took place at one institution only, and the design was adjusted accordingly.

### **3.3 The Research Process: Students**

#### **3.3.1 Recruitment and selection of students**

Recruiting eight students from my own polytechnic would be challenging, as there were only a small number of ESL students in the third year of the programme at the time (2008). A variety of recruitment approaches was therefore necessary.

As the available enrolment information on students did not include their first language, it was problematic to identify and target only those students from non-English-speaking backgrounds. In light of this, I decided to give information about the research study to all students about to undertake their Transition to Practice placement, with clear criteria for participation, and allow students to self-select on the basis of these criteria. As the students were on study leave during the recruitment period, it would be difficult to address them as a whole group, face-to-face. An invitation to participate in the research was therefore sent via email in the month before their Transition to Practice placement, with an information sheet and consent form (see Appendices 1, 2 and 3).

All information about the study was presented in English. I judged this to be appropriate given that these students had completed two-and-a-half years of nursing study in an English-speaking environment. As third-year students about to enter the New Zealand workforce as registered nurses, the use of English as a medium of communication was therefore acceptable.

I was also able to give a short face-to-face presentation and invitation to participate at a third-year pre-placement meeting in the week before placement. 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

Information about the research project was also sent to the staff in the Student Learning Centre. These staff members were helpful in disseminating information about the project to eligible students.

Seven students subsequently contacted me (either face-to-face or via email) and offered to participate in the study. Each agreed to be interviewed three times during the placement, for the interviews to be recorded, and for the data to be used in this thesis.

### **3.3.2 Characteristics of students**

Pseudonyms have been used throughout this report in order to respect confidentiality and ensure anonymity. Students were given the opportunity to choose their own pseudonym, if they wished. In addition, all students have been referred to as female. This was necessary to protect all students' identities.

The students' backgrounds and general characteristics are summarised in Table 3.1 below. Five of the students were of East

Asian background (from China, Korea and Hong Kong) and two students were from the Pacific Islands. There were six participants, ranging in age from 25 to 33. All but one student had spent time in New Zealand before commencing nursing training; the remaining student had spent a year in Australia. Four students had completed formal English language study prior to being accepted onto the programme (there was an entry requirement of IELTS 6.5 for entry, for international students); one student had completed two years' high school in New Zealand; one student had lived in New Zealand for a year; one student had completed a NZ qualification in communication and was married to a Kiwi. Five of the seven students had experience of working in a New Zealand health care setting, for example as an assistant in a rest home.

### **3.3.3 Pilot study**

Interviews were the main data collection tool. As Kvale says, "interviews are particularly suited for studying people's understanding of the meanings in their lived world, describing their experience and self-understanding, and clarifying and elaborating their own perspective on their lived world" (2007, p. 46).

I had originally planned to test the effectiveness of the interview techniques by talking to students completing an earlier placement. In the event, the timing of placements precluded this. However, I was able to arrange an interview with a student who had recently completed a resit of her Transition to Practice placement, and this gave me an opportunity to test the interview questions. The questions and associated prompts worked well, and no further modifications were made.

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

Student	Age	Region of Origin	Time in NZ	Previous education	Health Care Experience
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>	None
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>	None
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>	Part-time work in a rest home before studying
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>	Caregiver for those with intellectual disabilities
Sharon	33	Pacific Islands	4 years	High school in home country	Caregiver in rest home – one year before enrolling in BN, and during first year of study
Joey	30	Pacific Islands	7 ½ years	High school in home country Communication studies in New Zealand	Part time caregiver, in rest home / hospital

### **3.3.4 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 students all chose to come to the polytechnic for their interviews, which took place in a small, private study room with comfortable chairs, in a part of the campus away from the School of Nursing. This setting was chosen to put students at their ease and to provide reassurance that the research was independent of their programme of study. Students came for the interviews at times that were convenient for them, often combining this with other tasks on campus, for example appointments at the Student Learning Centre.

Jo, whose placement was out of town, agreed to be interviewed mid placement by telephone. Joey missed her mid-placement interview, due to illness.

The interviews were semi-structured; an interview guide was developed to provide a framework for each round of interviews (see Appendices 4, 5 and 6). It was important that the interviews were comfortable for the students and allowed them to explore issues of personal importance, while still ensuring that key themes were covered. In this respect, they aligned with Kvale's description of a semi-structured life-world interview: "neither an open everyday conversation nor a closed questionnaire" (2007, p. 11).

Care was taken to avoid asking the interviewees leading questions, and prompts such as 'Tell me more ...' were used to encourage elaboration of areas of interest. All interviews were recorded, with the permission of the interviewees. My aim throughout each interview was to stick to the well-known advice 'Ask as few questions as possible, and gather as much information as possible about those questions'. In this way, I hoped to collect focused information that would provide valuable data on my key research questions.

## **Student interview one**

The first interview had three main sections:

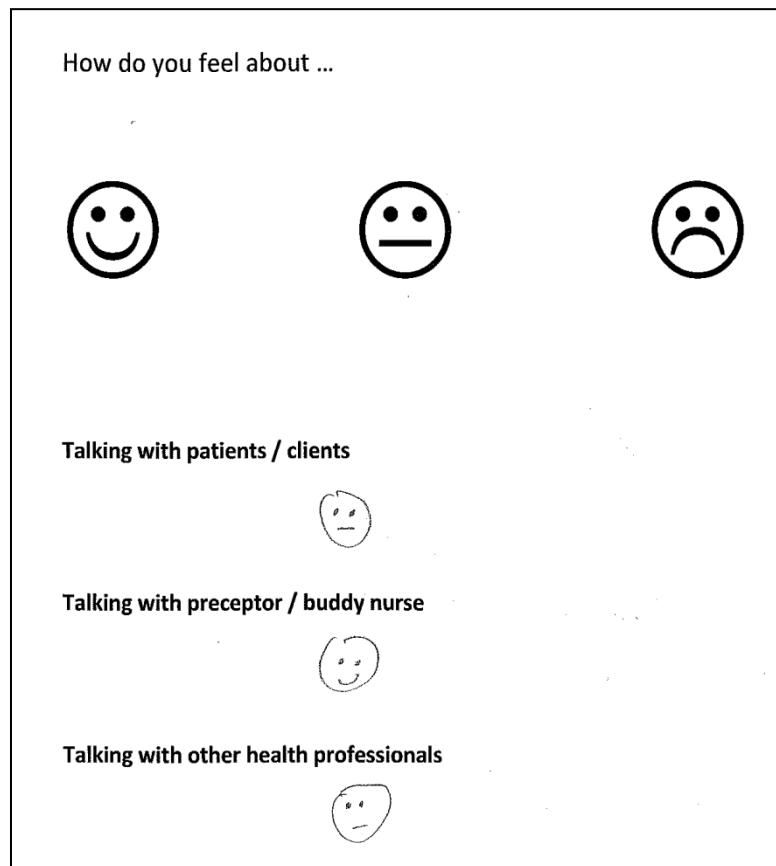
- General introduction and explanation of the project, and questions designed to gather background information about each student. Using questions to gather biographical data about the students rather than a paper-based questionnaire would, I hoped, enable me to establish rapport and build a comfortable relationship with each student.

This section included a paper-based exercise to support and stimulate discussion about the student's everyday use of English (see Appendix 7). This exercise was based on the English Language Acculturation Scale – ELAS (Salamonson, Everett, Koch, Andrew and Davidson, 2008).

- 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 comfort in communicating with the various groups on placement by drawing a happy, indifferent or unhappy face for each group: patients, preceptor and other health professionals. Students repeated this exercise at each interview. An example of a completed exercise is shown in Figure 3.2 below.



**Figure 3.2: Example of completed confidence in communicating exercise**

- **Aspects of spoken language use**

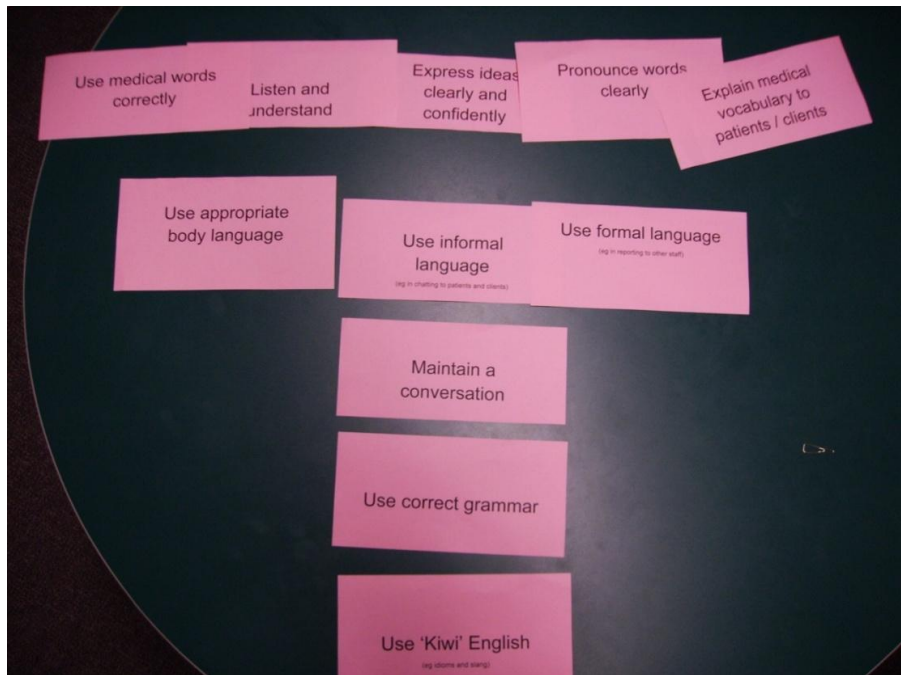
The second was a ranking exercise, based on models of communicative competence (for example Canale and Swain, 1980; Bachman, 1990). Students were given cards on which were written aspects of language that roughly correlated to the main components of communicative competence, as follows (see Table 3.3). It should be noted that the aspects of spoken language use 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.

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

<b>Component of Communicative Competence</b>	<b>Aspect of spoken language use</b>
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 'Kiwi' 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>

Students were then asked to order the cards in order of importance, and invited to create further cards for any other aspects they considered to be 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.





**Figure 3.4: Example of ‘aspects of spoken language’ exercise**

- The final part of the interview was designed to allow students to talk freely about their experiences with clinical placements. Glesne and Peshkin (1992) suggest the use of what they term a ‘magic wand’ question to encourage this kind of open and frank discussion. Accordingly, students were invited to reflect on their experiences by imagining they had been given the power to ask for positive change: ‘If you could ask the lecturers to do one thing to help you with communication in placement, what would it be?’

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. In the second and third interviews, this was often the point in the interview at which students told me about their interviews and job offers, and their plans for the future.

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.

Students shared their personal thoughts and experiences with me during the interviews, and I was concerned that they should take something of benefit for themselves. I offered each student a small gift at the end of each interview, as a token of appreciation for giving up time during this busy period of their lives. It was especially pleasing to me that students spontaneously expressed their appreciation at being given an opportunity to talk freely about their experiences in the programme, to have their 'voice' heard, and to reflect on communication issues. This accorded with Kvale's observation that "a common experience after research interviews is that the subjects have experienced the interview as genuinely enriching, have enjoyed talking freely with an attentive listener and have sometimes obtained new insights into important themes in their life worlds" (2007, p. 56). It was reassuring that students felt some personal benefit in return for their participation in the study.

### **3.3.5 Emails on placement**

At an early stage in planning, I had considered asking students to write a reflective journal during their placement. However, during conversations with clinical lecturers, I realised that students had a large assignment to do during the placement, and also often found the placement experience very tiring. In light of this, I changed my plans and instead 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. I presumed that emailing would be easier and less onerous than a reflective journal. Although some students did email me, the emails were 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.

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

The clinical lecturer visits the student during the placement, and provides feedback on performance, in consultation with the preceptor. Normally each student is assigned one clinical lecturer for the duration of the placement. Each lecturer, however, works with several students. I wanted to talk to as many lecturers as possible who had worked with, or who had an interest in, ESL students. 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.

### **3.4.1 Focus group**

Clinical lecturers are extremely busy, so I took advice on the day and time that would allow the maximum number of staff to be available. I emailed an invitation to attend the focus group to all clinical lecturers, with information about the research and a consent form (see Appendices 8, 9, and 10). A topic guide was formulated, in order to focus the discussion on key questions but leave enough room for exploration of issues that arose (see Appendix 11).

The focus group was scheduled for a mid-morning slot, and morning tea was provided. A small room away from the nursing school was booked for the group: taking time out from the normal working environment would, I hoped, facilitate relaxed and open discussion and interaction.

The key questions were circulated to those who had accepted the invitation, to allow participants time for reflection in advance. Four lecturers attended the group. Each lecturer gave informed consent to participate in the group, and for the group's interactions to be recorded and transcribed. Although I had hoped for greater numbers, it proved to be a lively and interactive session, with a useful exchange of views. The lecturers were also asked to do the 'aspects of spoken language use' exercise as a group; this provided a change of pace and focus, and allowed further discussion and interaction as the lecturers worked together to reach a mutual decision on the importance of the various aspects of communication.

The lecturers agreed that taking time out from their schedules to attend the group had been a useful experience, providing opportunity for reflection.

## **3.5 The Research Process: Preceptors**

### **3.5.1 Recruitment and selection of preceptors**

The preceptor is the registered nurse in the placement setting who is assigned to the student during the placement. The preceptor works alongside the student, observes the student 'in action', and provides regular feedback to the student and clinical lecturer on the student's performance. Preceptorship is an integral part of a registered nurse's role. An experienced registered nurse can be invited to act as a preceptor for a student or a new graduate.

Originally I had planned to interview each student's preceptor towards the end of the placement. The majority of the students were undertaking placement at a local hospital, so I approached the Nurse Manager, Nursing Practice Development for permission to contact the preceptors and conduct interviews. Once permission was obtained, an invitation to participate and information about the study was forwarded to the relevant charge nurses, who passed this on to the preceptors (see Appendix 12). However, during the course of an interview, one of the students expressed reservations. She had shared a range of feelings about her preceptor, and felt uncomfortable about my planned interview with this person.

Although all other students were willing for me to talk to their preceptors, it was necessary to protect the anonymity and confidentiality of this student. If all the preceptors were interviewed with the exception of the preceptor in question, it would be obvious that this preceptor's student had raised concerns. To avoid this, I decided to interview only two of the remaining preceptors, rather than all of them. Two preceptors were invited at random to be representative of this group, and both agreed to participate in the study.

Both preceptors chose to be interviewed at their place of work. An interview guide was developed (see Appendix 13), and both preceptors agreed for the interviews to be recorded and transcribed

(see consent form, Appendix 14). The interview guide focused on the same key questions as the lecturers' focus group; however, in addition to the 'aspects of spoken language use' exercise, the preceptors were asked to rate their student's ability in communicating with key groups. This would provide a useful comparison with the student's self-assessment of their confidence in communicating.

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

### Weeks of Transition to Practice Placement

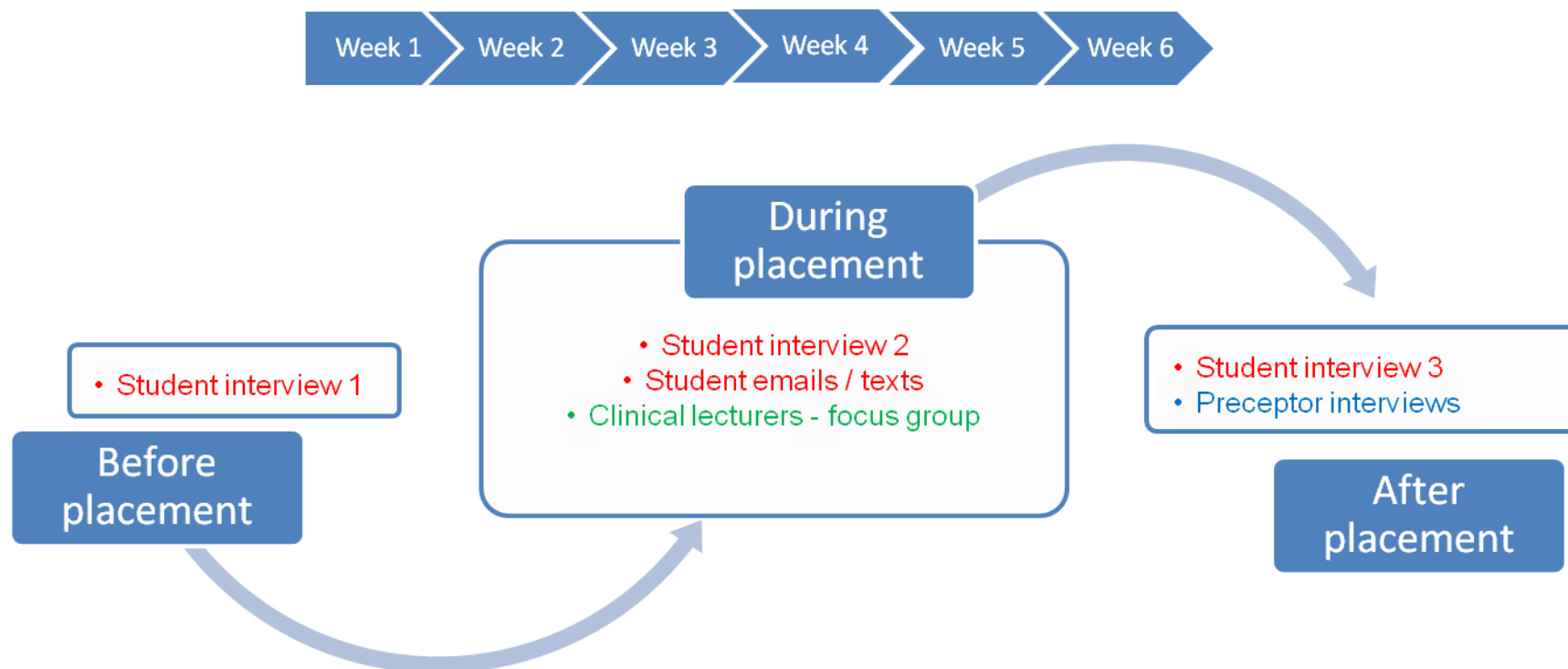


Figure 3.5: The data collection timeline

### **3.6 Data Analysis**

The interviews, focus groups, 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. I then read each transcript and listened to the associated recording several times to identify each student's 'voice' and ensure I had interpreted the student's intentions correctly. 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.

# Chapter Four

## Results: Finding a Voice

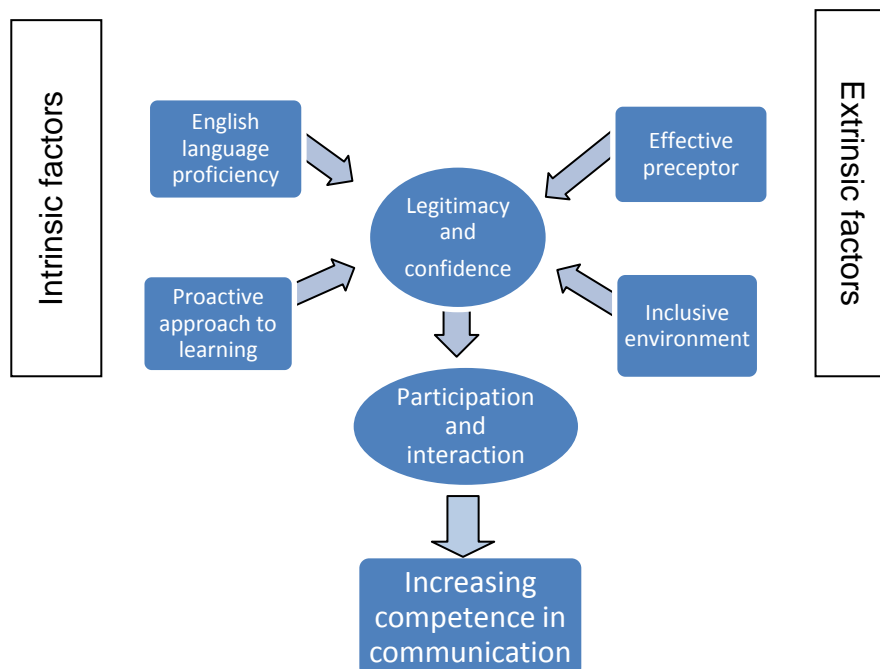
This chapter presents the analysis of data from the student interviews, emails and texts, the interviews with preceptors, and the focus group of clinical lecturers. The main factors that emerged as significant to students' ability to communicate effectively on placement are outlined and supported with excerpts from transcripts.

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 an overview of participants’ suggestions for ESL student support.

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).



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

## 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)

'Good' English was obviously considered important to a successful placement for ESL students. The 'aspects of spoken language' exercise, which was completed by all participants, provided useful information on how they perceived 'good' English for placement. The main findings are summarised in Table 4.2 below. It is important to note here that this exercise was most useful in promoting discussion about aspects of English for placement, rather than in providing an 'end result' of ordered cards. The aspects of language covered were difficult for some participants to interpret, and most required explanation of what was meant by terms such as 'use informal language' or 'maintain a conversation'. There was general agreement that many of these aspects were interrelated and overlapping, and so difficult to place in definitive order of importance. Most participants, therefore, placed items in groups of relative importance. The table below provides data on how many times each factor was placed in the 'most important' group.

**Table 4.2: Language proficiency factors ranked by importance**

<b>Aspect of language proficiency</b>	<b>Number of time ranked 'most important'</b>
Listen and comprehend	16
Express ideas clearly and confidently	14
Pronounce words clearly	8
Use medical words correctly	7
Explain medical vocabulary to clients	6
Maintain a conversation	6
Use appropriate body language	4
Use formal language	4
Use informal language	4
*Initiate conversations	1
*Ask questions	1
*Use a telephone	0
Use correct grammar	0
Use Kiwi English	0

\* These aspects were suggested and rated by individual participants

All three groups (students, clinical lecturers and preceptors) clearly agreed on the factors that were most important. The aspects of language proficiency that were consistently identified in the 'most important' category by all three groups were 'listen and comprehend' and 'express ideas clearly and confidently'. This was predictable as, together, these aspects could be said to represent the broad and essential categories of receptive and productive language, mastery of which enables fluent speech. Pronunciation, the ability to use and explain medical vocabulary, and the ability to engage in and maintain conversations were also rated as 'most important' by members of all groups.

All three groups were also in agreement about the least important factors. These were the ability to use 'Kiwi' English and correct grammar. When questioned about the low rating given 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. Most participants also pointed out that while correct grammar was important in written English, it was not so important in spoken English.

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 4.3 below is a pictorial representation of these findings. 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. Use of informal/formal language and use of appropriate body language have not been included as separate aspects; rather, they are assumed as subcategories of aspects such as 'engage in and maintain conversations' and 'express ideas clearly and confidently'.

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

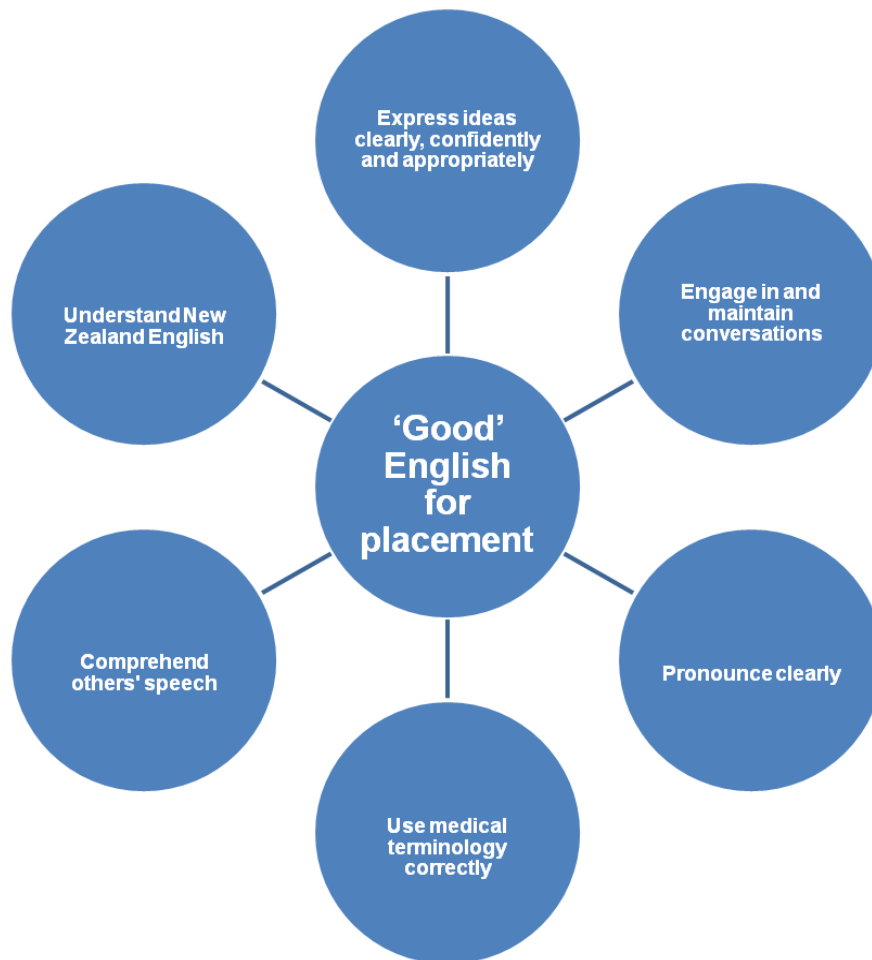


Figure 4.3: Elements of 'good' English for communication in placement

#### 4.1.1 Express ideas clearly, confidently and appropriately

As they progressed through their placement, all students experienced some problems with their spoken communication, including the strategic competence that would allow them to negotiate meaning. 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. Pronunciation and knowledge of relevant vocabulary, both important to fluent expression, are considered separately below.



### **Lack of automaticity**

Six of the students attributed some communication difficulties to the necessity of translating thoughts from a first to a second language. Whilst they had ideas and knowledge 'in their heads', they struggled to communicate these in English. The time needed to process information between languages impacted on conversations with colleagues, and could be construed by others as a lack of understanding:

For me, like, in my mind I have a lot of thinking. Yeah. It's in [my first language], so I have to translate. So I'm quite speak slowly. Sometimes I just missed, missed ... something that I want to say. Yeah. That's problem. (Jo 2)

Turning thoughts from a first to a second language demanded energy. When students became tired or stressed, the effort of translation could be overwhelming. 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. Clinical placements are, in themselves, likely to create just such conditions. Students must adapt to a full-time working environment, which may include unusual hours and evening shifts, on top of study-related tasks (for example, the students in this study had an assignment to complete during their placement). They are also constantly under pressure to perform and to demonstrate the necessary competencies. These pressures are likely to affect students' performance in the second language.

### **Difficulty with pragmatic rules of New Zealand English**

As noted in section 2.2, the use of a bald imperative structure when making requests is grammatically correct. However, this may not be the most appropriate form of language for the context and purpose, and may be interpreted by others as impolite. In the nursing workplace, where clients are often feeling unwell or uncomfortable and where it is necessary to build effective therapeutic relationships, nurses often formulate requests using sophisticated hedging and softening devices.

It was evident in the study that some students lacked the pragmatic skills needed to 'soften' instructions, and that as a result they were perceived as 'bossy' or abrupt. 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. This was evident from comments such as the following, in which Sylvia is discussing the difficulties of asking a client about bowel habits:

I think if I use my language I can – I got the way to ask it nicely, but if I use English, I don't know, I just can use the simple way to ask, and I don't know how to make it nicely. So this is the hardest part. Sometime people may think, 'Oh you are rude!' But I don't mean it that way. (Sylvia 1)

### **Interference from first language**

As mentioned previously, inadequate knowledge of the sociopragmatic rules underlying appropriate language use could cause problems in communication. This included situations in which the student inappropriately transferred some pragmatic conventions from their first language to the second language. For successful communication to take place, both speaker and listener must understand the intended illocutionary force (or purpose) of the utterance (see Bachman's model of language competency, section 2.1). 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.

#### **4.1.2 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 here centred on correct use and pronunciation of medical terminology, considered in sections 4.1.3 and 4.1.6 below.

While transactional communication about medical matters might be expected to be the most important form of communication for a nurse in a clinical setting, research has shown that over half of nurses' daily interactions are interpersonal in nature, designed to build effective social relations with patients and colleagues (Holmes & Major, 2003). Initiating and maintaining informal social conversations is therefore an important skill, both when interacting with colleagues and when working with patients. Problems with social conversations or 'chatting' were a recurrent theme throughout the data. 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 challenge of chat**

The ability to form relationships with patients through skilful use of social chat has been linked with effective nursing. Engaging patients through the use of anecdotes, personal experiences and other forms of small talk helps to put them at ease, to be comfortable in the clinical environment, and to establish an effective therapeutic relationship (Fenwick, Barclay & Schmied, 2001). This use of social talk is an expected part of the nurse's role in New Zealand.

However, perceptions of the nurse's role differ across cultures. Initiating and engaging in this social chat could be problematic for ESL students from a cultural background that had 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)

Students also need to engage in social chat with colleagues, in order to fit into the workplace and to establish effective working relationships (Holmes 2005). Again, this aspect of a nurse's role varies across cultures. Some of the students in the study expressed the opinion that talk with both patients and colleagues within the placement should be confined to medical or nursing issues, reflecting cultural norms at odds with those expected in New Zealand. It therefore cannot be assumed that ESL students will understand the importance of informal chat and social interaction to their nursing practice.

Even when students did understand the importance of engaging in social chat, they experienced a range of difficulties in achieving it. These included the challenge of New Zealand colloquialisms and humour (identified as an important language factor by all groups – see section 4.1 above), and finding suitable topics of conversation. Joey, for example, found it challenging to find topics suitable for

patients of differing age groups: “You can’t really be talking about the weather with every client that comes in, you know?” (Joey 3). Jo was able to talk to patients about nursing issues, but if they talked about other things, such as football, she “had no idea” (Jo 3).

Shared topics of conversation were also problematic when talking with colleagues: “Sometime when they talk – talk about their family or their children, and I mean I come here by myself. You can’t really join in” (Rose 2). For this student, differing life circumstances made it difficult to share in others’ social conversation, and she was not confident enough to initiate discussion on alternative topics. Rose was also aware that because she could only give short answers to questions, people sometimes viewed her as unfriendly: “For me I knew that I’m interesting in them, but I just can’t talk more because of my limitations with the language” (Rose 2).

When students were given explicit instruction on the importance of social talk and interaction with colleagues, they were able to reflect on this, what it would mean and how to accomplish it. For example, Bobbi was given feedback that she needed to interact more with other members of staff. She took the feedback on board, considered it and adopted strategies to engage in conversation. However, this process was not easy:

So I just ask myself what do they mean, I’m not really talk with them? I talk with them. And how can I talk with them? I ask myself and I thought, ‘Okay, make a change’. And from next week, I just try to find any interesting topic to talk with them or something like this. And finally they said I’m great and excellent, yeah, but I was really stressed. Very scary. (Bobbi 1)

While Bobbi had improved her ability to engage in conversation with colleagues, it had taken a great deal of personal effort and courage.

### **4.1.3 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. Tina, the student who experienced the greatest difficulty with pronunciation, sometimes needed the preceptor to translate her speech for colleagues or clients. 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 and irregular spelling patterns associated with medical terminology created difficulties with pronunciation.

#### **First language interference**

Certain sounds could be problematic, due to interference from the student's first language. Jo, for example, had trouble with the phonemes /f/, /l/ and /r/. In her first language there is no phoneme /f/ and the phoneme /l/ has a complex pattern of realisations. This meant that some frequently-used words on placement that included these phonemes were problematic. Another example was Rose, who also 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. Sylvia experienced a strong negative reaction from a patient who found her accent difficult:

One lady, I tried to tell her about ... do you know that oxygen sats, to check your oxygen level, and you know what did she ... she heard 'oxygen apple'. And she said to me, "Speaking English please". (Sylvia 3)

Such reactions had a negative effect on students' sense of themselves as potential professional practitioners, and on their perceptions of their language competency. This in turn affected their willingness to communicate: they 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. The pronunciation of this terminology was mentioned as a recurring difficulty by all students in the study.

### **Medical terminology**

Pronunciation of medical terminology, such as the names of drugs and medical procedures, was a major challenge for most of the students. 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)

Other students expressed similar difficulties with words such as 'jaundice', 'hysterectomy' and 'cellulitis'. Although they were able to read these terms and understand them when used by others, they



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.

#### **4.1.4 Comprehend others' speech**

##### ***'I have no idea what they talking about' (Rose 3)***

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' speech at times. The most common reasons were speech that was too fast, unfamiliar vocabulary (particularly slang and idioms, or colloquial terms), and unusual accents (for example when working with overseas staff). Misinterpretations could arise from students' lack of familiarity with pragmatic conventions of New Zealand English. From the lecturers' point of view, students' tendency to cover up lack of comprehension rather than request clarification was a major problem.

##### **Unfamiliar vocabulary**

While medical terminology was a major area of difficulty (see section 4.1.6), the lay-medical register used in New Zealand could also be problematic, especially when talking to patients. 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 (see section 4.1.7). 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)

Other words that caused difficulty were those with multiple meanings dependent on context, for example 'booking' or 'stool'. These common expressions are taken for granted by native speakers as part of background knowledge, but may present challenges for ESL students.

### **Misinterpretation**

Students in the study expressed their experiences of misunderstanding others' speech. As mentioned in section 4.1.1, lack of understanding of pragmatic rules of language, 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.

### **Failure to clarify instructions**

Rather than attempting to clarify their understanding, students sometimes used strategies such as avoidance, 'guessing' what others were saying, or pretending to understand, in order to avoid appearing incompetent. Jo described how she avoided situations that might reveal her lack of comprehension: "Sometimes I just pretend to understand, I just pretend or just want to escape this situation" (Jo 1). As Lave and Wenger (1991) point out, learning involves gradually taking on a new identity: the identity of a legitimate member of the community of practice. Gradual competency in the practices of the community is co-incident with a growing sense of identity as member of that community. To reveal a lack of understanding therefore threatens students' growing perception of themselves as legitimate members of the nursing community. It might also lead to marginalisation or exclusion from the community, and so is to be avoided if possible.

Strategies such as avoidance or pretending to understand are potentially dangerous. They can compromise patient safety, for example when preceptors mistakenly assume the student's comprehension of a critical instruction. During the focus group, the clinical lecturers described several incidents where ESL students failed to clarify their understanding of an important instruction. In one incident a student almost administered a drug to a baby rather than its mother:

She checked the drug and so that's fine, 'cos the preceptor said, "Yes, that's the right drug," and then the preceptor looked round and saw her heading for the baby, not the mother.

So that's that bit of thinking she understood, the nurse thinking she understood. (CL)

Incidents such as these illustrate the critical importance of both student and preceptor understanding and implementing strategies to check understanding.

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

The term 'Kiwi' English was used in the 'aspects of spoken language' exercise to denote speech that included New Zealand cultural references, colloquialisms, idioms and humour. Participants in the study all felt that understanding this speech was an important but challenging factor for ESL students on placement. It was needed in order to identify important information, for example when taking patients' health histories, and to enable students to engage in informal social conversations with patients and colleagues.

Students were aware that an understanding of these aspects of language would benefit their relationships with patients:

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)

Idiomatic expressions such as 'cool bananas', 'push the envelope' and 'sweet as' were cited by students as problematic.

The underlying pragmatic rules of New Zealand English could also prove difficult for students, as has been noted above.

#### **4.1.6 Use medical terminology correctly**

***“I have no problem to work with my preceptor, except when she talked about meds or technical terms.” (Sylvia, email 26 Aug)***

As mentioned in section 4.1.3, pronunciation of medications and other medical terms caused all students some anxiety. Learning the terminology associated with their particular placement setting and using it appropriately in conversation with other staff were further areas of difficulty.

#### **Learning terminology for the setting**

In addition to general medical and nursing terminology, students needed to become familiar quickly 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)

Jo experienced this difficulty during her first week in the operating theatre. She had to learn the names of the surgical instruments, which was particularly challenging, as described in her email to me:

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)

The task was made more difficult because everyone in the operating theatre had to wear a mask and this muffled their speech so that she had to ask for clarification: “Say that again, please” (Jo 3).

Although all students would probably find mastering each new set of terminology difficult, ESL students faced the extra challenge of achieving this in a second language and so required more time and practice than their non-ESL counterparts.

### **Using terminology with colleagues**

All students found talking to doctors or other senior staff stressful, because it involved using, understanding and pronouncing medical terminology:

I’m still a bit scared, talk to the doctors. Because I think problem is I was scared about sometimes if they saying anything about medical terminology, if I didn’t know what I am going to do, yeah I’m scared about that. (Tina 2)

The difficulty of using medical terminology in conversations with colleagues was a recurring theme at all stages of the placement, and for all students. During her final interview, Bobbi described her plan to improve her knowledge of medical terms so that she could relate to the team more easily. She recognised the value of devoting time and focussed attention on learning how to interact appropriately with other team members:

Certainly my plan is, short period of time, make myself more familiar with medical words. Because in the future I will work in a very professional team ... I know they will talk to each other, you know formal language, so I hope I can – I quite feel stressful though sometimes – but I hope I can, you know, understand as much as possible. (Bobbi 3)

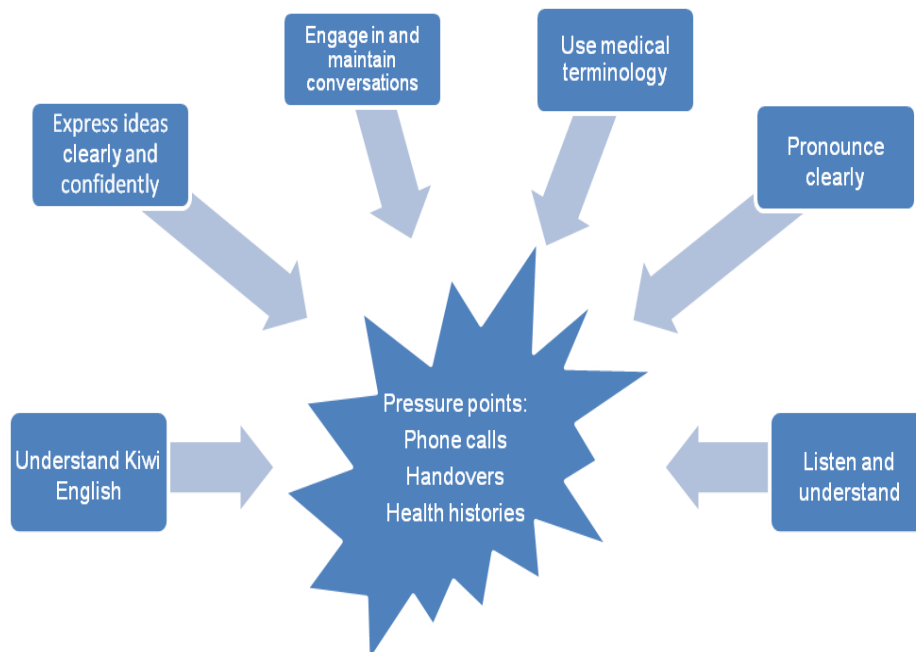
Students were aware of their difficulties with medical terminology, and were keen to improve, often going to great lengths to practise the terminology in their own time, outside the placement.

#### **4.1.7 Pressure points**

Certain routine situations 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 4.4 below). During the focus group, the lecturers described how the language anxiety caused by 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)

Rose, Bobbi, Jo and Sylvia found some routine tasks particularly stressful in terms of communication. Making and receiving telephone calls, taking patients' health histories, and handovers of patient information at the beginning and end of shifts were all challenging. Each of these activities required competent use of a particular discourse style or genre.



**Figure 4.4: Pressure points for communication**

### **Talking on the phone**

Talking on the telephone involves a distinctive style of discourse, with particular conventions. Students need to be very familiar with these conventions, in order to engage in telephone conversations with confidence. They also need to be confident in using strategies to clarify information.

Four students referred to answering the phone as a task that caused anxiety. They worried about talking to someone unknown, about that person's reaction, and about their own ability to understand the message. The problems were worse if other people could overhear the conversation. Revealing a lack of comprehension could lead others to question the student's legitimacy in the community of practice, and thus threaten their identity as a future nurse. These fears could lead the student to cover up the lack of understanding, and thereby potentially compromise patient safety. There was one report of a student taking a call from the laboratory. She needed to record the patient's name and the result of tests. Because there



were other people around, she was too nervous to ask the speaker to spell the name, and so just guessed it.

### **Health histories**

Many of the students, including Sylvia, found the routine task of taking a patient's health history on admission particularly challenging. The form used to complete the history may consist of several pages, each requiring students to find out key information from the patient, for example on their eating habits and bowel and urinary patterns (see Figure 4.5). This necessitates both understanding the medical vocabulary used on the form (for example, 'oral mucosa', 'alleviating factors', 'dorsalis pedis') and being able to translate this into lay medical language for the patient. The student must then listen to the patient's response, pick out the important information, and record it using the correct medical terminology. If students do not understand the patient's response, perhaps because the patient has used unfamiliar lay medical terms or colloquial language (such as 'throwing up' for vomiting or 'the runs' for diarrhoea), they must be able to clarify their understanding by asking appropriate questions. All this must be completed under pressure of time, and as the completed form will be used by senior colleagues, and is important to patient safety, it is important that it is completed correctly. Sylvia summed up the students' views on this procedure: "I *hate* that health history. Sometimes the patient they are so complicated" (Sylvia1).

Tina found it difficult to identify the main points in patients' narrative responses: "I still found hard to gather health history from patients during admission, especially people with story talk that I couldn't pick up main point" (Tina, email 24 August).

### **Handovers**

Handovers are verbal reports given by nurses to their colleagues about the patients in their care. They are typically given at the end of

Figure 4.5: Pages from a 'Health history' form

<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p style="text-align: center; margin: 0;">PATIENT ID LABEL</p> </div> <p>PREFERRED NAME: _____ HISTORY OBTAINED BY: _____          REASON FOR ADMISSION: _____ DATE OF ADMISSION TO WARD: _____          ASSOCIATED MEDICAL CONDITION(S): _____ TIME OF ADMISSION TO WARD: _____</p> <p style="text-align: center; font-weight: bold;">             FLAG:    P = Problem    * = Risk Management    E = Education    R = Referral         </p> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p><b>ALLERGIES:</b> No known allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>              (Sensitivities) _____ ATTACH STICKER</p> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p><b>INFECTION CONTROL: Alert on file?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>MRSA - known positive: <input type="checkbox"/> No <input type="checkbox"/> Yes              MRSA - problem hospital or rehome, or overseas 3 mths? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ (which hospital)              Infectious condition? <input type="checkbox"/> No <input type="checkbox"/> Yes Needs isolation? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ (type) Infection Control notified <input type="checkbox"/>              Isolated patient/turoro requirements: <input type="checkbox"/> Door notice <input type="checkbox"/> Information Leaflets <input type="checkbox"/> Masks/gowns/gloves <input type="checkbox"/> Equipment Kit              Need MRSA swabs (ANY hospital or rehome outside MCH 3 mths, MRSA alert, boils/ulcers/wounds)? <input type="checkbox"/> No <input type="checkbox"/> Yes              SET 1: <input type="checkbox"/> Nose <input type="checkbox"/> Groin <input type="checkbox"/> Other _____ SET 2 (&lt; 48 hr s later): <input type="checkbox"/> Nose <input type="checkbox"/> Groin <input type="checkbox"/> Other _____              OTHER: Any known infectious diseases? <input type="checkbox"/> No <input type="checkbox"/> Yes              If yes, details (eg TB, pseudomonas, etc) _____ Isolation type _____ Init: <input type="checkbox"/></p> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p><b>ROLE RELATIONSHIP (NEXT OF KIN/CONTACT PERSON):</b></p> <p>NOK Name _____ Relationship _____              Phone: (Home) _____ (Work) _____ (Cellphone) _____              Contact person/s if different from NOK:              Name _____ Relationship _____              Phone: (Home) _____ (Work) _____ (Cellphone) _____              NOK/Contact person aware of admission: <input type="checkbox"/> No <input type="checkbox"/> Yes Understands phone info policy: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>PATIENT/TURORO'S SIGNATURE</b></p> <p>Household occupants (dependents, spouse etc) _____              Concerns about home situation: Admission _____ Discharge _____              Current community resources utilised: <input type="checkbox"/> No <input type="checkbox"/> Yes Specify _____              Leisure activities _____              Occupation _____ Concerns _____              See 'Home Section' in Discharge Plan _____ Init: <input type="checkbox"/></p> </div> <div style="border: 1px solid black; padding: 5px;"> <p><b>ORIENTATION TO WARD:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <input type="checkbox"/> Ward location  <input type="checkbox"/> Introduction to other patients  <input type="checkbox"/> Telephone  <input type="checkbox"/> Toilet/Bathroom  <input type="checkbox"/> General Information Sheet signed  <input type="checkbox"/> Patients Rights                             </td> <td style="width: 50%; border: none;"> <input type="checkbox"/> Cell phones  <input type="checkbox"/> TV Policy  <input type="checkbox"/> No smoking policy  <input type="checkbox"/> Lounge  <input type="checkbox"/> Hospital Information Brochure  <input type="checkbox"/> "Tell us what you think" Brochure  <input type="checkbox"/> Other (specify) _____                             </td> <td style="width: 50%; border: none;"> <input type="checkbox"/> Intro to Nurse  <input type="checkbox"/> Call bell  <input type="checkbox"/> Visiting hours  <input type="checkbox"/> Meal times  <input type="checkbox"/> Own clothes                             </td> </tr> </table> <p style="text-align: right;">Init: <input type="checkbox"/></p> </div>	<input type="checkbox"/> Ward location <input type="checkbox"/> Introduction to other patients <input type="checkbox"/> Telephone <input type="checkbox"/> Toilet/Bathroom <input type="checkbox"/> General Information Sheet signed <input type="checkbox"/> Patients Rights	<input type="checkbox"/> Cell phones <input type="checkbox"/> TV Policy <input type="checkbox"/> No smoking policy <input type="checkbox"/> Lounge <input type="checkbox"/> Hospital Information Brochure <input type="checkbox"/> "Tell us what you think" Brochure <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Intro to Nurse <input type="checkbox"/> Call bell <input type="checkbox"/> Visiting hours <input type="checkbox"/> Meal times <input type="checkbox"/> Own clothes	<p style="writing-mode: vertical-rl; transform: rotate(180deg); font-weight: bold; font-size: 1.2em;">NURSING ASSESSMENT</p>
<input type="checkbox"/> Ward location <input type="checkbox"/> Introduction to other patients <input type="checkbox"/> Telephone <input type="checkbox"/> Toilet/Bathroom <input type="checkbox"/> General Information Sheet signed <input type="checkbox"/> Patients Rights	<input type="checkbox"/> Cell phones <input type="checkbox"/> TV Policy <input type="checkbox"/> No smoking policy <input type="checkbox"/> Lounge <input type="checkbox"/> Hospital Information Brochure <input type="checkbox"/> "Tell us what you think" Brochure <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Intro to Nurse <input type="checkbox"/> Call bell <input type="checkbox"/> Visiting hours <input type="checkbox"/> Meal times <input type="checkbox"/> Own clothes		
<p style="text-align: right; font-weight: bold;">FLAG</p>				
<p><b>NUTRITION-METABOLIC PATTERN:</b></p> <p>Temp _____ C Height _____ Weight _____</p> <p><b>Usual Eating Pattern</b></p> <p>Diet: <input type="checkbox"/> Diabetic - usual blood sugar _____  <input type="checkbox"/> Fluids <input type="checkbox"/> Light <input type="checkbox"/> PEG Tube  <input type="checkbox"/> NBM <input type="checkbox"/> Neutropenic  <input type="checkbox"/> Normal <input type="checkbox"/> Soft  <input type="checkbox"/> Thickened <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan  <input type="checkbox"/> Other _____</p> <p>Appetite: <input type="checkbox"/> Normal <input type="checkbox"/> Small <input type="checkbox"/> Large          Nausea: <input type="checkbox"/> No <input type="checkbox"/> Yes          Vomiting: <input type="checkbox"/> No <input type="checkbox"/> Yes          Weight changes: <input type="checkbox"/> No <input type="checkbox"/> Yes          Specify _____</p> <p>Alcohol intake: <input type="checkbox"/> No <input type="checkbox"/> Yes          Amount _____</p> <p><b>Teeth:</b> <input type="checkbox"/> Own <input type="checkbox"/> Dentures          Partial plate: <input type="checkbox"/> Top <input type="checkbox"/> Bottom          Comments _____</p>				
<p><b>Integument</b></p> <p><b>Oral Mucosa:</b> <input type="checkbox"/> Moist <input type="checkbox"/> Intact <input type="checkbox"/> Ulcerated <input type="checkbox"/> Dry          Comments _____</p> <p><b>Nails:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Overgrown <input type="checkbox"/> Infected <input type="checkbox"/> Clipping          Comments _____</p> <p><b>Skin Turgor:</b> <input type="checkbox"/> Dry <input type="checkbox"/> Elastic          Comments _____</p> <p><b>Skin:</b> <input type="checkbox"/> Intact <input type="checkbox"/> No <input type="checkbox"/> Yes          Specify _____  <input type="checkbox"/> Abrasions <input type="checkbox"/> Rashes <input type="checkbox"/> Bruises  <input type="checkbox"/> Lesions <input type="checkbox"/> Petechiae <input type="checkbox"/> Pressure damage          IV Access: <input type="checkbox"/> No <input type="checkbox"/> Yes Type _____ Site _____          Date of insertion _____ Site Check _____</p> <p><b>Wound:</b> Location _____          Type: <input type="checkbox"/> Surgical <input type="checkbox"/> Ulcer <input type="checkbox"/> Pressure Sore  <input type="checkbox"/> Burn <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____          Wound Chart completed: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A          Init: <input type="checkbox"/></p>				
<p><b>ELIMINATION PATTERN:</b></p> <p><b>Gastrointestinal/Bowels:</b></p> <p>Usual bowel pattern _____          Last bowel action _____          Recent changes to bowel pattern: <input type="checkbox"/> No <input type="checkbox"/> Yes          Bowel sounds: <input type="checkbox"/> Present <input type="checkbox"/> Absent</p> <p><b>Urinary:</b></p> <p>Recent changes to voiding pattern: <input type="checkbox"/> No <input type="checkbox"/> Yes          Urinalysis result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p><b>Problems:</b> <input type="checkbox"/> Pain <input type="checkbox"/> Straining <input type="checkbox"/> Constipation <input type="checkbox"/> Blood  <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Laxative use <input type="checkbox"/> Ostomy          Aids: <input type="checkbox"/> No <input type="checkbox"/> Yes Specify _____          Abdominal examination _____          Comments _____</p> <p><b>Problems:</b> <input type="checkbox"/> Flow <input type="checkbox"/> Blood <input type="checkbox"/> Pain <input type="checkbox"/> Burning  <input type="checkbox"/> Odour <input type="checkbox"/> Nocturia <input type="checkbox"/> Frequency _____          Aids: <input type="checkbox"/> No <input type="checkbox"/> Yes Specify _____          Can reach toilet on time: <input type="checkbox"/> No <input type="checkbox"/> Yes          Bladder examination _____          Comments _____          Init: <input type="checkbox"/></p>				
<p><b>SEXUALITY REPRODUCTIVE PATTERN:</b></p> <p><b>GENERAL HEALTH -</b>          Do you see your GP about any of the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <p><b>Female:</b></p> <p>Cervical Smear: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Breast Examination: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____</p> <p><b>Male:</b></p> <p>Testicular Exam: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Prostatic Exam: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Information sheet given: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> </td> <td style="width: 50%; border: none;"> <p>In relation to your treatment, is there any possibility you:</p> <ul style="list-style-type: none"> <li>* Could be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* If yes, verbal consent for pregnancy test? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* May have been exposed to a sexually transmitted infection? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* Have you been given information in relation to sexual activity? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</li> </ul> <p>Init: <input type="checkbox"/></p> </td> </tr> </table>		<p><b>Female:</b></p> <p>Cervical Smear: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Breast Examination: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____</p> <p><b>Male:</b></p> <p>Testicular Exam: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Prostatic Exam: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Information sheet given: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>In relation to your treatment, is there any possibility you:</p> <ul style="list-style-type: none"> <li>* Could be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* If yes, verbal consent for pregnancy test? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* May have been exposed to a sexually transmitted infection? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* Have you been given information in relation to sexual activity? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</li> </ul> <p>Init: <input type="checkbox"/></p>	
<p><b>Female:</b></p> <p>Cervical Smear: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Breast Examination: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____</p> <p><b>Male:</b></p> <p>Testicular Exam: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Prostatic Exam: <input type="checkbox"/> No <input type="checkbox"/> Yes Year _____                  Information sheet given: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>In relation to your treatment, is there any possibility you:</p> <ul style="list-style-type: none"> <li>* Could be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* If yes, verbal consent for pregnancy test? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* May have been exposed to a sexually transmitted infection? <input type="checkbox"/> No <input type="checkbox"/> Yes</li> <li>* Have you been given information in relation to sexual activity? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A</li> </ul> <p>Init: <input type="checkbox"/></p>			
<p>* REFER TO BACK PAGE</p>				

each shift, as nurses pass on responsibility for the care of these patients to a new set of nurses. Handovers necessitate the use of correct medical terminology and must be given orally in real time and in front of senior colleagues. They also involve discussing patient care with other staff members, and both asking and answering questions. In this situation, ESL students must face the risk that senior colleagues will witness their lack of fluency. This creates a great deal of stress, as students perceive this exposure could threaten their acceptance as members of the community of practice, and their growing identity as legitimate members of this community.

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 informal 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 4.6 below. The next section considers the second factor that students bring to the placement setting: their use of a proactive approach to learning.



## 4.2 Intrinsic Factors: Proactive approach to learning

*“When in Rome do what the Romans do. You know? For me it was something like ‘OK, I’m going to NZ, I’m have to be open to this.’” (Joey 1)*

Nursing students on placement are expected to display a proactive approach to learning, actively seeking relevant learning opportunities (see section 1.2). This requires confidence, the ability to be assertive and negotiate with those in authority, and a clear understanding of your right to learn from others. Such a proactive 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.

### 4.2.1 Asking questions

Clinical lecturers and preceptors agreed that asking questions was fundamental to learning in placement. However, to do this, students must be comfortable with the concept of learning as a partnership between student and teacher. ESL students have to adjust to “The Kiwi culture of communication, our communication culture, where it’s okay to ask questions, okay to challenge ... that whole concept of partnership” (L).

All students in this study 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.

As mentioned in section 4.1.4, asking for clarification is important for patient safety. The students in the study varied in their attitudes towards asking questions, but all 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. For Bobbi, it was only towards the end of her final placement that she fully realised the importance of asking questions:

I think the first, second, third time it is really hard, but after that you will feel very, you know, happy to ask questions. Because once you ask you actually thinking, once you thinking you want to know and once you ask you know it, so you’re learning. (Bobbi 3)

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.

#### **4.2.2 Seeking and responding to feedback**

The preceptor and clinical lecturer both have responsibilities to provide regular feedback on the student's performance (NETS/NENZ, 2007). However, it is also expected that the student will actively seek feedback from the preceptor, on a daily basis. Most students in this study found this difficult as it involved identifying a time when the preceptor was not busy 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. Two students, Sharon and Joey, began the placement with a proactive approach, determined to seek feedback. For Sharon, this was a deliberate strategy which she felt able to put into practice at this point in her study. While she had recognised its importance for some time, it was only in her third year that she felt able to implement it fully in the placement environment.

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 he or she may be experiencing. 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. In her culture, revealing a lack of

understanding could be implied as disrespectful, reflecting negatively on the teacher's skills. As a result, she felt obliged to say that everything was going well, even when she was experiencing problems.

### **4.2.3 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)

During the focus group, clinical lecturers described how 'passive' students may be viewed as 'special needs' by nursing staff, and so be assigned routine, undemanding activities. 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.

Joey realised the importance of this assertive behaviour, and adopted it from the start of her placement:

As soon as my preceptor says, "Oh there's this, this, you can do it, do you want to do it?" "Yes," before even she says no. Because I see it's a learning experience for me. I won't get a chance like this again. (Joey 1)



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. In the following extract, Sylvia is commenting on the difficulties of delegating tasks to nursing assistants:

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.

#### **4.2.4 Identifying as a nursing student**

The majority of the students described themselves as different from 'Kiwi' students, with particular needs. They attributed any 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).

Along with this confidence in their own ability came a realistic expectation that the quality of their experience on placement would depend on their attitude as a learner:

They are some ups and down in every ward, and not all the staffs are good. Some are good and some are not and then you have to gain experience from both staff.  
(Sharon 1)

This positive attitude seemed to contribute to a smoother and more effective journey through the placement (see section 5.2).

## **4.3 Extrinsic Factors: Effective preceptor**

**“Actually with our experience – good or not – entirely depend on the preceptor ... They have huge impact on us.” (Sylvia 1)**

The quality of the preceptor greatly impacted on students' experience in placement. Being assigned a 'good' preceptor, who was able to support the student's entry to the community of practice and confirm their position of legitimate participation, made the placement much smoother and enhanced the learning experience. Having a 'difficult' preceptor, who blocked rather than facilitated student's access to the interactions of the placement, was disempowering and made the experience stressful.

### **4.3.1 The role of the preceptor**

The NETS/NENZ Joint Position Statement on Clinical Practice Experience for Undergraduate Nursing (2007a) outlines the role of the preceptor. The preceptor is expected to provide regular daily feedback to the student, ensure that the clinical environment is 'conducive to learning' and monitor that the student is 'free from harassment or bullying' (p4).

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 any such training. 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. Being available “if they need any help or need to ask any questions” (P1) was an important part of this process.

### 4.3.2 Student perceptions of ‘good’ preceptors

The students also had firm ideas on what made a ‘good’ preceptor. They valued preceptors who were inclusive, approachable, encouraging and who had effective teaching strategies (see Table 4.7). A preceptor with these qualities could greatly increase students’ confidence and willingness to interact with others, and facilitate their integration within the placement setting.

**Table 4.7: Qualities of a ‘good’ preceptor**

Characteristics of a ‘good’ preceptor as perceived by students
Inclusive
Approachable
Encouraging
Caring
Non-blaming
Patient
Explains clearly
Models skills/language/behaviour
Checks student’s understanding

#### **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. Inviting students to join them on breaks, or showing where students could make themselves a hot drink were examples of how a preceptor could show a caring attitude:

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)

This welcoming attitude helped to confirm students' position of legitimate peripheral participation in this community of practice (Lave & Wenger, 1991).

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.

Other preceptors failed to provide the scaffolding that would facilitate students' acceptance within the community, and thus access to the models of performance necessary for learning. Sylvia had worked with one such preceptor:

I work with one nurse for maybe a couple of days and she said to me, "Oh, I'm busy – you go to do your own work." And I thought, "Oh my goodness!" I didn't know anything. How can I do my own work? I come here supposed to work with you to learn things. But she just push you off. (Sylvia1)

This experience, in an early placement, had been confusing and discouraging.

### **Approachable**

Students needed to seek daily feedback from their preceptor within a busy environment. 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: "If the person is like, kind of easy to approach, I feel more confident and more like to approach her to talk to her. Otherwise I will very scared" (Bobbi 2).

One of the preceptors in the study recognised this and 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)

Two of the students in the study had particularly supportive preceptors who encouraged them on a daily basis, developing relationships with them that would have a lasting effect. Sharon commented that she would never forget her preceptor, who would be a role model for her future nursing practice (and own preceptorship);

Tina 'loved' her preceptor, who had become like a mother, and who spoke up for her at a critical moment, helping her to achieve her goal of passing the placement.

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 keep 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 teaching 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**

Preceptors who didn't take time to explain procedures or tasks were viewed less favourably by students. 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**

From the students' point of view, 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**

**“Depend on how lucky you are; depend on what kind of people you dealing with” (Sylvia 3).**

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.

### **4.4.1 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.

#### **Differentiated expectations and treatment**

Clinical lecturers described their experiences of how senior placement staff reported 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 (for example, ‘The third-year students’).

Preceptors’ previous experience with or preconceptions of 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.

Some students in the study agreed there could be differing expectations of Kiwi and ESL students. For example, if an ESL student did not understand a medical term, they might be told that, as a nursing student, they should know it. A Kiwi student in the same situation might meet with a more helpful response.

### **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)

Some students had experienced these negative attitudes on previous placements. During our first interview, Bobbi expressed her reservations about working in the hospital environment. Her experience was that staff members were not very welcoming. She attributed this to the fact that they had worked as a team for a long time and might find it hard to accommodate someone new, especially if that person looked and sounded different from them. This underlines the importance of providing students with strategies to facilitate their own access to the community of practice, through the exercise of personal agency.

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.

Most students in the study agreed that doctors and other senior health professionals could be difficult to deal with. At our final interview, Rose described a negative response from a house surgeon, which had affected her confidence in communicating with other medical staff:

His attitude just make me very, you know, I don't know ... very rude ... just very hard because it's my first day to approach that surgeon and then I just haven't got the, you know, very good – I don't know how to explain but yeah, just put me down. (Rose 3)

The difficulties in approaching and communicating with senior health professionals might be partly attributed to power imbalances between students and senior staff. These would also be likely to affect non-ESL students. However, for students working in a second language and who were already anxious about their communication, the effects of negative responses on confidence levels were magnified.

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.

Although all students had experienced negative attitudes during their placements, they also talked about placement environments that were welcoming and supportive.

#### **4.4.2 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:

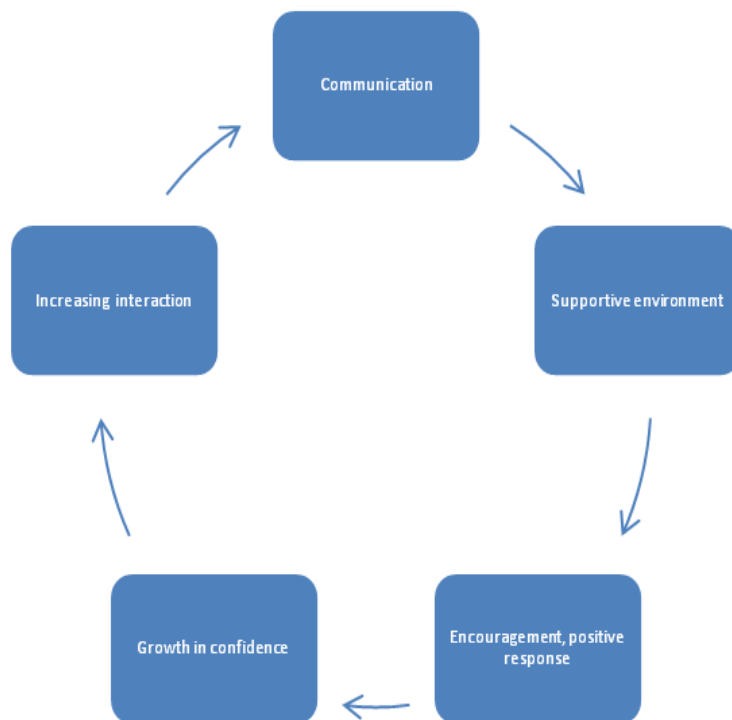
One ward that I work in, probably the top, most respected nurse in that setting is an African nurse, who is meticulous in her practice ... . I think the ward has respect for people of other nationalities because of that, whereas I have another ward ... and I have always have a problem on that ward, cos 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). Encouragement from patients could similarly boost students’ confidence in communicating:

One of my patient, she form a very good relationship, therapeutic relationship, with me, and I said to her, “Oh, thank you, you can understand my English and you be patient.” So she’s kind of quite encouraging. She said, “Oh, I can understand your English. No problem at all, don’t worry.”(Sylvia 1)

These encouraging attitudes and responses from others built confidence, which in turn led to further interaction, thus creating a positive cycle of growth (see Figure 4.8 below).



**Figure 4.8: Relationship between confidence, interaction and communication: positive cycle**

In this section, the data on four main factors influencing students' ability to communicate effectively on placement has been presented: English language ability, ability to adopt a proactive approach to learning, the quality of the preceptor and the tone of the environment. Running through these factors is an important connecting thread: confidence. The following chapter provides an overview of students' confidence growth during the placements, noting two main patterns or pathways.

# Chapter Five

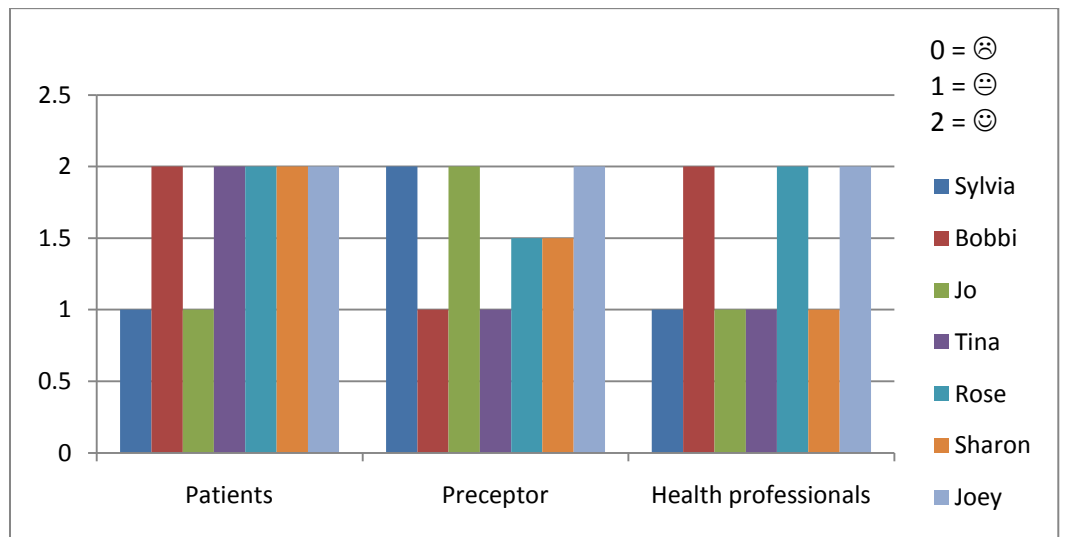
## Results: The Path to Confidence

This chapter presents data on the students' journeys through placement. Information from the paper-based exercise 'How do you feel about communicating?' was analysed alongside each student's interview transcripts to provide information on attitudes towards communication during the placement.

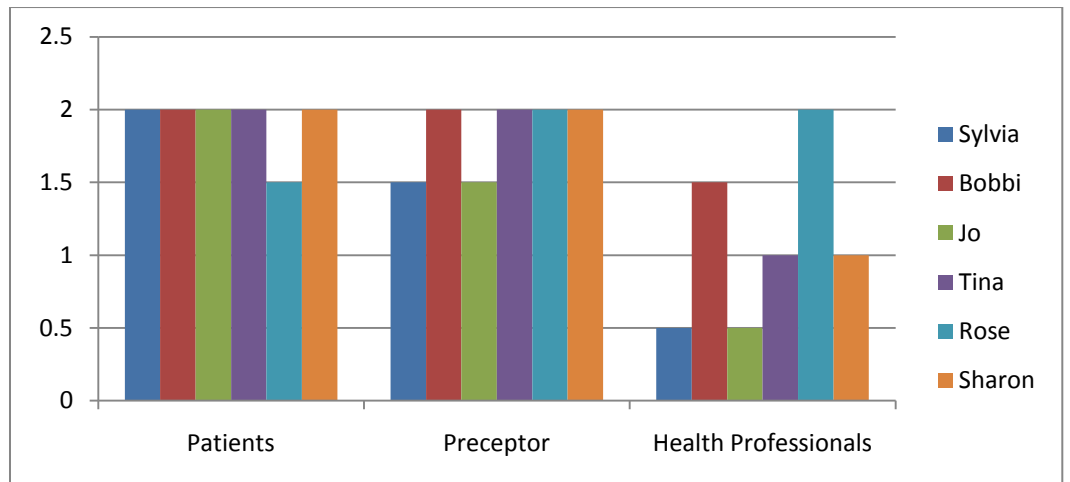
Full results from the paper-based exercise are shown in Figure 5.1. Students were asked to rate their confidence in communicating with each group (clients/patients, preceptors and other health professionals) by drawing a smiley face, an indifferent face or a sad face. For the purposes of graphical representation, these responses have been assigned the following numerical values: smiley face = 2, indifferent face = 1, anxious face = 0.

While all students reported a rise in overall confidence during the placement, two typical routes to this confidence could be identified. For the first group, the route was circuitous and involved some setbacks and false starts. For the second group, the route was more consistent and direct. A typical representation of each route, based on the information from the paper-based exercise, is shown in Figure 5.2.

### Interview 1



### Interview 2



### Interview 3

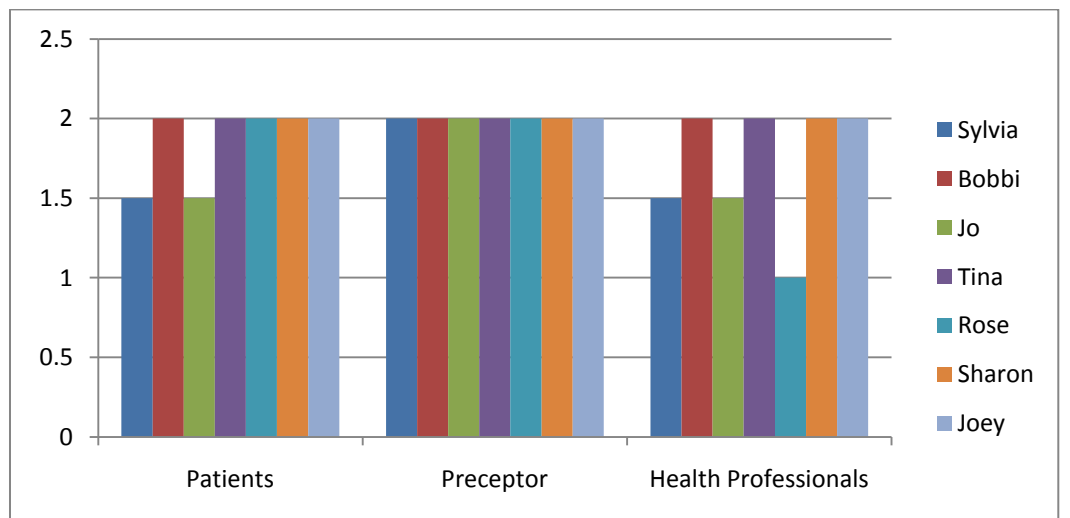


Figure 5.1: Confidence in communicating, as reported at each student interview



Group One: Two steps forward and one step back



Group Two: Full steam ahead

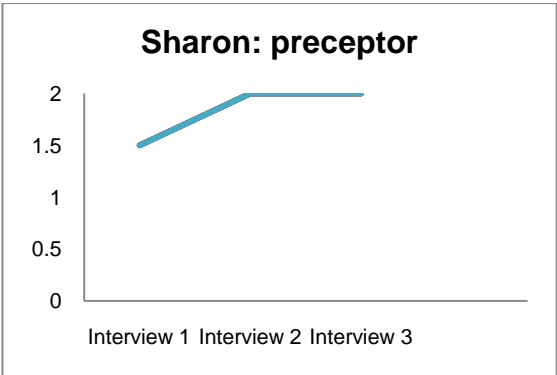


Figure 5.2: Paths to confidence in communicating in placement

## 5.1 Group One: Two steps forward, one step back

For Sylvia, Bobbi, Jo, Tina and Rose, all from East Asian backgrounds, confidence in communicating rose and fell through the placement, while increasing overall. Often a defining moment of crisis or critical feedback precipitated a change in behaviour and a subsequent confidence 'spurt'. Patterns of confidence at each stage of placement are described below.

### Pre-placement: anxiety

At the pre-placement interview, the most common attitude to communication on placement was anxiety, perhaps because these students had all experienced previous problems. In response to the question 'What do you think will be the most difficult thing for you?' all these students focussed on aspects of communication, such as using the telephone, contacting other staff and taking health histories (see Table 5.3).

**Table 5.3: Group one – predicted difficulties in placement**

	<b>Interview One:</b> <i><b>Q: What do you think will be the most difficult thing in placement?</b></i>
Sylvia	That one, before, I told you that interview things.
Bobbi	I think to deal with the staff.
Jo	Maybe answering phone? Answering phone.
Tina	To know how to contact different multidiscipline team members. Like how to contact the doctors, social workers, occupational therapist, like that.
Rose	It's still hard for me to pick up the phone, to answer the phone. It's very hard for me to understand over the phone.

Of the three main groups they would interact with on placement - patients, preceptors and other health professionals - students were most confident about communicating with patients. The exceptions were Sylvia and Jo, who were also the only two who had not worked in a New Zealand healthcare setting either during or before their study (for example as part-time care assistants). Students were slightly less confident about communicating with their preceptor and least confident about communicating with other health professionals.

### **Mid placement: Up and down**

The first week was difficult for most students, as they struggled to become familiar with the communication patterns and terminology associated with the new environment. By the time of their mid-placement interview, however, students had settled in and their confidence in interacting with patients and preceptors had grown. Sylvia relaxed as she realised that some of the patients' difficulties in understanding her were due to factors other than her level of English. Bobbi's preceptor was "very patient" in taking time to explain things, and always supportive and encouraging; because of this, Bobbi felt she was learning a lot.

In contrast, students' confidence in communicating with health professionals had dipped. Students worried about their command of terminology, and that they would not be able to understand or be understood, and that this might lead to a negative reaction from colleagues. Some students had already experienced these angry or negative responses, and so were trying to avoid further communication. For one student, understanding and remembering colleagues' names was difficult and led her to withdraw from interaction so as to avoid embarrassment.

Terminology was also problematic at this point, especially the names of conditions, procedures and medications. For Bobbi, working in recovery, this made handovers particularly difficult. She felt that

other staff members were “in a hurry”, and had an in-depth knowledge of conditions and medications which she hadn’t yet acquired. This added to the pressure and anxiety she felt.

### **Post-placement: Tentatively confident**

At this point, the students all knew they had passed the placement and were looking forward tentatively to their futures as registered nurses. They had all either maintained or increased their initial confidence in communicating with patients, and were fully confident in communicating with their preceptors. Most students had also begun to develop a measure of confidence in interacting with other health professionals.

This new-found confidence had typically developed in response to a defining, critical moment, which prompted them to move ‘out of the comfort zone’ and try new strategies.

For Tina and Jo, the ‘critical moment’ was direct feedback that their communication must improve in order to meet the standards for the placement. Jo was given clear feedback that she needed to improve her communication skills and interact more with the team, by talking to the nurses, anaesthetists and technicians. Jo realised that she had to make a change, and decided to use her colleagues’ speech as a model:

In the last week I really change, and I really tried to communicate with other health professionals, yeah. And then I copied like what the nurses say to others, and that works and I got the confidence so I could communicate with others. (Jo 3)

As a result, she described the last week of the placement as “really great!” Her confidence had increased enormously, and she had an obvious sense of achievement and excitement for the future.

Tina’s critical moment also occurred in response to feedback. She found the placement tiring, and had started to ring in sick in the fifth

week. Feedback from the preceptor was that her attitude wasn't right: she looked "totally pissed off". Most critically, a patient had complained about her. As Tina said, "People is thinking am I not happy to be there, I'm not happy to dealing with them, or am I grump" (Tina 3). With the support of her preceptor, the clinical lecturer agreed to allow Tina an extra week in placement to see if she could make necessary improvements.

This feedback, and the real possibility of failure, prompted Tina to make a concerted effort to change her attitude and also make sure she got plenty of sleep. These strategies worked well, and the lecturer commented that she seemed like a "completely different person".

For this group, the experience of placement had resulted in an increased sense of self-efficacy, or assessment of their own competence and effectiveness in communicating (Gecas, 1989). This was linked to increased confidence and to an increased willingness to participate in the interactions of the placement. However, communication was still perceived as problematic. When asked to describe the most difficult aspect of placement, all students talked about aspects of communication (see Table 5.4 below), especially understanding, using and pronouncing medical terminology.

**Table 5.4: Group one – actual difficulties in placement**

	<i><b>Interview Three</b></i> <i><b>Q: What was the most difficult thing in placement/?</b></i>
Sylvia	Still some medical term, yeah Pronounce some particular medical terms or medication
Bobbi	The handover Medical words
Jo	The name of instruments and suture name Telephone talking
Tina	The pronunciation about the drug names
Rose	Some nurse talk very fast and some surgeon is just ... some thing is new for me so I found it's very hard to catch. I have no idea what they talking about

## 5.2 Group Two: Full steam ahead

For Sharon and Joey, both from Fijian backgrounds, the journey was smoother. Their confidence in communicating with each main group either grew steadily or was maintained at a high level through the placement.

### **Pre placement: Positive expectations**

At their first interview, both Sharon and Joey were looking forward to the forthcoming placement and the opportunity to take on greater responsibility in practice. Joey was confident about communicating with all groups in placement. Sharon was fully confident in communicating with patients but slightly less confident about communicating with her preceptor. She was least confident about communicating with other health professionals.

In contrast to the students in group one, Joey's and Sharon's responses to the question 'What do you think will be the most difficult thing for you?' centred on factors other than language. Sharon set high expectations for herself, and felt that the most difficult aspect would be "performing" all the time. Joey was looking forward to a new clinical setting (a medical practice) and working with other health professionals, and did not foresee any difficulties (see Table 5.5).

**Table 5.5: Group two – predicted difficulties in placement**

	<i>Interview One</i>  <i>Q: So in your placement coming up, what do you think will be the most difficult thing for you?</i>
Sharon	Proving myself all the time.
Joey	(No direct response to question: positive outlook to placement.)

### **Mid placement: Confidence**

Sharon's relationship with her preceptor, who also spoke English as a second language, was very positive. At the mid-placement interview she was brimming with confidence. She had already been given the opportunity to take full responsibility for some patients, and she had no problems with communication. She had also dealt with challenging interpersonal issues in the placement and had used assertive communication to work these through to resolution.

Joey was unable to meet me for a mid placement interview, being tired from a long commute each day.

### **Post placement: Enthusiasm for the future**

At the end of their placements, which both had successfully completed, Sharon and Joey were secure in their abilities, and enthusiastic about their futures as registered nurses.

Sharon had managed a full patient workload, and had received feedback that her communication was "very good". The most challenging aspect of the placement had been getting used to the ward environment and routine. She struggled at times with expressing herself as fully as she would like in a second language, but explained this would develop over time, along with her clinical skills.

At our final interview Joey described how she had enjoyed being able to put theory into practice. The most difficult aspect of her placement had been other staff members' interpersonal issues. She had successfully communicated with other staff members and with health professionals such as a psychiatrist, drug rep and nurse practitioner. The only aspect of communication which could cause her difficulty was pronunciation of drug names.

These students began the placement with a positive sense of their competence in communicating, with a willingness to engage in the interactions of the placement, and with the ability to exercise personal agency to achieve this. The most difficult aspects of placement for them had been aspects other than communication, again in contrast with Group one (see Table 5.6 below).

**Table 5.6: Group Two – Actual difficulties in placement**

<i>Interview Three</i>	
<i>Q: What was the most difficult thing in placement?</i>	
Sharon	Getting used to the routine of that ward
Joey	Some of the things I saw there was not ... especially in regards to the staff members, you know, they didn't get along. So that was, yeah, a bit uncomfortable.

As part of our discussions, each participant in the study was asked what could be done to support ESL students' communication in clinical placement. The following section outlines the responses.

### **5.3 Supporting Students in Placement**

This was obviously a subject students felt passionately about, and they had many ideas for support, and talked freely and purposefully about this (see Table 5.7 for a summary of responses). One of their suggestions was to integrate ESL students more effectively within the mainstream programme, by drawing on their experiences and cultural backgrounds. This would enrich the mainstream programme and would also increase ESL students' sense of membership of the wider student body, therefore helping them to identify first and foremost as nursing students. Other suggestions included dedicated academic and pastoral support for ESL students, and extra preparation for clinical placements. Clinical lecturers agreed that ESL students require more flexibility around the timing of



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 5.7: Participants' suggestions for ESL student support**

placements, in order to allow the development of the necessary skills while working in a second language.

The clinical lecturers also pointed to the need for a specific orientation to the Bachelor of Nursing programme for ESL students. This could cover topics such as the role of the nurse in New Zealand, the New Zealand healthcare system, and academic and workplace expectations.

The participants in the study agreed unanimously on the need for a 'preparation for placement course' designed specifically for ESL students, with a focus on effective communication.

## **5.4 Conclusion**

While all the students in this study passed their Transition to Practice placement, the journey involved challenges for each of them. These challenges had, at times, seemed to threaten their success, and some students struggled to adjust their style of interaction in response to feedback. For two of the students, this turnaround occurred at the last minute, under great pressure.

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. This was a privilege which I gratefully acknowledge. Each journey was unique, a testament to the individual concerned as they negotiated their 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.

# Chapter Six

## Discussion and Implications

This section will interpret and discuss the 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.

### 6.1 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.

#### 6.1.1 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 – see section 2.1 above), 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 emerged through the data as particularly important for communication in placement, and 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, particularly when these could be interpreted in a variety of ways, depending on how they were said and what the context was. 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 was 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 for those people and contexts 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 Boshier and Smalkowski (2002). This lack of confidence 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.

### **6.1.2 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.

### **6.1.3 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 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.

#### **6.1.4 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.

### **6.1.5 The role of confidence**

When students engaged in interaction that was successful in terms of communication, their belief in their ability to produce successful communication 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'.

## **6.2 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

### **6.2.1 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 is 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 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.

### **6.2.2 Proactive approach to learning**

Students require support and encouragement to acquire the proactive strategies that optimise effective learning in clinical placements. A communication for placement programme (see section 6.2.1) 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 or 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.

### **6.2.3 Matching ESL students with supportive preceptors and colleagues**

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' as outlined in section 4.3.2, 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 have 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.

#### **6.2.4 Fostering an inclusive atmosphere throughout the programme**

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, Phillipines 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)

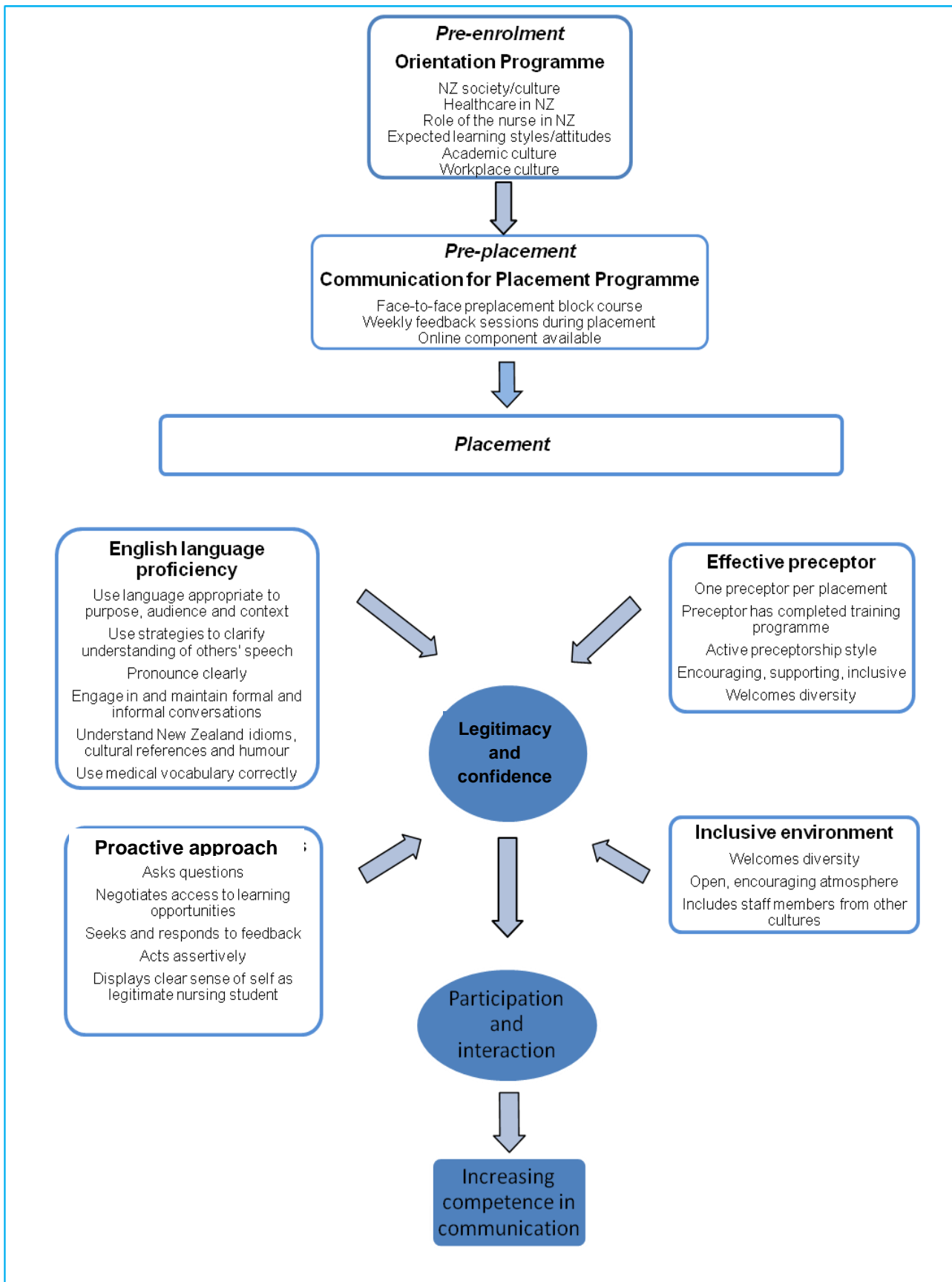
In addition, students often felt alienated and excluded by their fellow students; this experience contributed to their view of themselves as different, as ESL students rather than part of the wider body of nursing students.

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).

### **6.3 The Optimum Situation**

The results of the research 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 6.1, which might be said to represent the optimum or ideal situation for an ESL student on placement.



**Figure 6.1: Factors and support mechanisms to facilitate effective communication and participation**

# Chapter 7

## 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.

## **7.1 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 (1991): 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 everyday, 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.

Findings 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. Student satisfaction in our programmes is important, as it will support increased retention and completion. Ensuring that the needs of ESL students within our programmes are adequately catered for is an important part of achieving these levels of student satisfaction.

# Appendices

## Appendix 1: Student invitation to participate

### *Invitation*

*For all students who speak English as a Second Language*

Hi! My name is Jan. I am an academic advisor at XXXX and I have also taught English to university students in New Zealand.

I am doing research for my Masters degree. My research will look at the experiences of Bachelor of Nursing students who speak English as a second language.

- ❖ *Do you have a first language other than English?*
- ❖ *Are you doing your Transition to Practice placement in August?*
- ❖ *Were you born in a country other than New Zealand?*
- ❖ *Do you speak a language other than English at home?*

Did you answer "Yes" to all of those? Then I would really like you to be part of my research team!

## *The ESL Team*

I want to set up a team of ESL students to help with my research. I hope the research will help us to understand the clinical placements better, so we can support ESL students in the future.


*Interested?*


If you think you might like to meet with me and talk to me about your experience in clinical placements, read the Information Sheet.

*Still interested?*

**Then:**

 E-mail me with your contact details at \_\_\_\_\_  
or:

 Telephone me at \_\_\_\_\_  
or:

 Print this sheet of paper, fill in your details below, and hand it to the Student Services Centre.

Your name: .....

How can I contact you? .....

## Appendix 2: Student information sheet

[Print on Massey University departmental letterhead]

[Logo, name and address of Department/School/Institute/Section]

# Communication in Clinical Practice

## Critical Success Factors for ESL Students

July 2008

Dear Bachelor of Nursing students,

My name is Jan Eyre and I am doing research for my Masters degree in Second Language Teaching. I am looking at the experiences of nursing students who have a first language other than English. I am particularly interested in students' experiences of clinical placements. My focus is on the English language and communication that is needed in clinical placements, and how to help students with this.

I am an academic advisor at XXXXXX, and I have also taught English as a Second Language.

### ***Why am I doing this study?***

I think it is important to find out more about the experiences of students, so we can make clinical placements as successful as we can for everybody.

### ***What am I going to do?***

I want to talk to third-year nursing students who have a first language other than English, and who were born in a country other than New Zealand. They can be international students, or students who live in New Zealand but who speak a language other than English at home.

If you join the project, I will ask you to:

- Meet and talk with me as you start your Transition to Practice placement, once during your placement, and once after your placement. Each session will last no more than an hour.
- Tell me how you are feeling, what you are finding difficult and what is going well as you complete your clinical placement.
- Write a short email to me once a week during your placement, to tell me how things are going for you.

I want to talk to about six students. If too many people volunteer, I will make a random selection and tell you whether you have been selected or not.

***Will anyone else know what you told me?***

I will tape our conversations and then transcribe them (write them out), but you can choose to turn off the tape recorder at any time. Some of the information you tell me might be in my Masters thesis. However, I will not use your name and I will make sure that nobody can identify the students involved. The tapes and transcripts will be kept confidential. If you want, I can give you a summary of the information when the project is finished.

***What rights do you have?***

You are a volunteer in this research, so you have the right to:

- decide not to take part (there will be no problems for you if you decide not to take part);
- change your mind and decide not to take part any more at any time;
- ask me any questions about the research at any time;
- talk to me knowing that I will not use your name unless you give me permission;
- decide not to answer a question if you don't want to;
- ask me to turn off the tape recorder at any time during our conversation;
- check and make changes to my transcript of our conversation;
- be given a summary of the research findings.

***Any questions?***



You can ask me questions about the research before you agree to take part. You can contact me by e-mail \_\_\_\_\_ or telephone \_\_\_\_\_.

Or you can ask one of my supervisors, Dr Gillian Skyrme, School of Language Studies, Massey University, extension 7754 (g.r.skyrme@massey.ac.nz), or Dr Martin Paviour-Smith, School of Language Studies, Massey University extension 2195 (m.paviour-smith@massey.ac.nz).

***What should you do next?***

See the instructions on the cover sheet which tell you how to contact me. I will then contact you to find out how I can meet you.

***Thank you for reading all of this. I really look forward to meeting you soon.***

Best wishes

*Jan Eyre*

*This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research.*

*If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Ethics & Equity), telephone 06 350 5249, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz).*

## Appendix 3: Student consent form

Communication in Clinical Practice: Critical Success Factors for ESL Students

### CONSENT FORM: STUDENT INTERVIEWS

**THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF  
FIVE (5) YEARS**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interview being audio-taped.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name:**

**(please print)**

.....

I would like to check the transcript of my interviews

Yes

I would like to receive a summary of the results of the project

Yes

when it is finished.

**Email address:** .....

**Telephone number:** .....

**Address:** .....

## **Appendix 4: Student 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?
- Paper-based exercise (see Appendix 1)

## 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 on placement? (See Appendix 2)
- Exercise – ranking of communication skills (See Appendix 3)
- Who do you go to if you need help with communication in placement?
- What is your experience of the study and conversation groups offered by the Student Support Services?

## 6 Conclusion

- What has been the biggest help for you, in learning to communicate in practice?
- If you could ask the lecturers to do 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?

## Appendix 5: Student Interview Guide (2)

### 1 Introduction

- Use of tape recorder
- Information will be confidential
- No right or wrong answers
- You don't have to answer any questions you don't want to
- You can ask to turn off the tape at any time
- Do you have any questions?
- Sign / date the consent form

### 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

#### *Paper-based ranking 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?

- Emails – is there a better way to communicate with you, for example chat room / online discussion forum?

## Appendix 6: Student Interview Guide (3)

### 1 Introduction

- Use of tape recorder
- Information will be confidential
- No right or wrong answers
- You don't have to answer any questions you don't want to
- You can ask to turn off the tape at any time
- Do you have any questions?
- Sign / date the consent form

### 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?

*Smiley face exercise – confidence in communicating*

*Language factor ranking 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?



## Appendix 7: Language Acculturation Exercise

	Non-English	More non-English than English	Non-English and English equally	More English than non-English	Only English
In what language do you usually <b>read</b> ?					
In what language do you usually <b>speak</b> ?					
What language do you usually <b>speak at home</b> ?					
In what language do you usually <b>think</b> ?					
What language do you usually <b>speak with your friends</b> ?					

## Appendix 8: Clinical lecturers' invitation and information sheet

# Communication in Clinical Practice

## Critical Success Factors for ESL Students

July 2008

Dear

I am conducting research for my Masters degree (MPhil) on the experiences of nursing students who have a first language other than English. I am particularly interested in students' experiences of clinical placements. My focus is on the communication skills that are needed in clinical placements, and how to help students develop these.

I am an academic advisor at XXXXXX, and I have also taught academic writing, intercultural communication and English as a Second Language to tertiary students.

As part of my research, I would like to talk to lecturing staff who have worked with ESL students on clinical placements.

I also plan to interview ESL students as they complete their Transition to Practice placement, and the preceptors who work with these students.

I would really like you to be part of this project, and would welcome your attendance at a focus group. The purpose of the focus group is to explore lecturers' experiences of working with ESL students on placements, and their perceptions of the challenges and issues concerning communication for these students.

The focus group will be held on campus, and will last no more than an hour. I will audiotape the focus group conversation and transcribe it, and may use some of the information in the project report. However, I will make sure that the lecturers involved cannot be identified. The tapes and transcripts will be kept confidential. Participants may ask for the audiotape to be turned off at any time during the focus group.

Participation in the focus group is voluntary. If you decide to take part, you have the right to:

- provide information on the understanding that your name will not be used;
- decline to answer any particular question;
- withdraw from the project at any time;
- ask questions about the project at any time;
- be given a summary of the project findings when it is finished.

I am happy to answer questions about the research before you agree to take part. You can contact me by e-mail \_\_\_\_\_ or telephone \_\_\_\_\_.

Or you can ask one of my supervisors, Dr Gillian Skyrme, School of Language Studies, Massey University, extension 7754 (g. r.skyrme@massey.ac.nz), or Dr Martin Paviour-Smith, School of Language Studies, Massey University extension 2195 (m.paviour-smith@massey.ac.nz).

### **What should you do next?**

Please email or phone me as soon as possible to register your interest in being part of the focus group. I will contact you to confirm a date and time for the group.

Thank you for reading all this. I really look forward to meeting you soon.

Best wishes

*Jan Eyre*

Email: \_\_\_\_\_

Tel: \_\_\_\_\_

*This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research.*

*If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Ethics & Equity), telephone 06 350 5249, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz).*

## Appendix 9: Clinical lecturers' consent form

Communication in Clinical Practice: Critical Success Factors for ESL Students

### CONSENT FORM: LECTURING STAFF FOCUS GROUP

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF  
FIVE (5) YEARS

I have read the Information Sheet and have had the details of the project explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the focus group being audio taped.

I agree to participate in this project under the conditions set out in the Information Sheet.

**Signature:** ..... **Date:** .....

**Full Name:**  
**(please print)** .....

I would like to check the transcript of the focus group Yes

I would like to receive a summary of the results of the project Yes

when it is finished.

**Email address:** .....

**Telephone number:** .....

**Address:** .....

## **Appendix 10: Clinical lecturers' focus group topic guide**

### **1 Introduction**

Who I am, purpose of the research: 'To identify barriers to success for ESL students in clinical placement, with a focus on the communication skills needed for a successful placement. The aim is to identify strategies that can help future ESL students have a successful experience in clinical placement.'

Am working with seven students completing their transition to practice placement – have done two out of three interviews with each student.

Also want to collect the views of those who've worked with ESL students on placements - lecturers and preceptors.

- 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 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 language use exercise**

How important to communication in clinical are the following?

Rank the cards in order of importance.

## Appendix 11: Preceptors' invitation and information sheet

# Communication in Clinical Practice

## Critical Success Factors for ESL Students

July 2008

Dear

I am conducting research for my Masters degree (MPhil) on the experiences of nursing students who have a first language other than English. I am particularly interested in students' experiences of clinical placements. My focus is on the communication skills that are needed in clinical placements, and how to help students develop these.

I am an academic advisor at XXXXXX, and I have also taught academic writing, intercultural communication and English as a Second Language to tertiary students.

As part of my research, I would like to talk to preceptors who have worked with ESL students on clinical placements.

I also plan to interview ESL students as they complete their Transition to Practice placement, and hold a focus group of lecturing staff from the Bachelor of Nursing programme.

I would really like you to be part of this project, and would like to meet and talk with you about your experiences with ESL students on placements, and your perceptions of the challenges and issues concerning communication for these students.

I would like to meet at a convenient location for you, for no more than an hour. I will audiotape our conversation and transcribe it, and may use some of the information in the project report. However, I will make sure that you cannot be identified. The tape and transcripts will be kept confidential. You may ask for the audiotape to be turned off at any time during our meeting.

Participation in the project is voluntary. If you decide to take part, you have the right to:

- provide information on the understanding that your name will not be used;
- decline to answer any particular question;
- withdraw from the project at any time;
- ask questions about the project at any time;
- be given a summary of the project findings when it is finished.

I am happy to answer questions about the research before you agree to take part. You can contact me by e-mail \_\_\_\_\_ or telephone \_\_\_\_\_.

Or you can ask one of my supervisors, Dr Gillian Skyrme, School of Language Studies, Massey University, extension 7754 (g. r.skyrme@massey.ac.nz), or Dr Martin Paviour-Smith, School of Language Studies, Massey University extension 2195 (m.paviour-smith@massey.ac.nz).

### **What should you do next?**

Please email or phone me as soon as possible to register your interest in being part of the focus group. I will contact you to confirm a date and time for the group.

Thank you for reading all this. I really look forward to meeting you soon.

Best wishes

*Jan Eyre*

Email: \_\_\_\_\_

Tel: \_\_\_\_\_

Mobile: \_\_\_\_\_



*This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research.*

*If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Ethics & Equity), telephone 06 350 5249, email [humanethics@massey.ac.nz](mailto:humanethics@massey.ac.nz).*

## **Appendix 12: Preceptors' interview guide**

### **1 Introduction**

Who I am, purpose of the research: 'To identify barriers to success for ESL students in clinical placement, with a focus on the communication skills needed for a successful placement. The aim is to identify strategies that can help future ESL students have a successful experience in clinical placement.'

I am working with seven students completing their transition to practice placement, and have completed two out of three interviews with each student.

Also want to collect the views of those who've worked with ESL students on placements - lecturers and preceptors.

- 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?
- Tell me about working with \_\_\_\_\_. What particular challenges does she face, in the clinical setting?
- 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 Confidence in communicating exercise**

### **4 Aspects of spoken language exercise**

## Appendix 13: Preceptors' consent form

Communication in Clinical Practice: Critical Success Factors for ESL Students

### CONSENT FORM: PRECEPTOR INTERVIEW

**THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF  
FIVE (5) YEARS**

I have read the Information Sheet and have had the details of the project explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interview being audio taped.

I agree to participate in this project under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name:**

**(please print)**

.....

I would like to check the transcript of the interview

Yes

I would like to receive a summary of the results of the project

Yes

when it is finished.

**Email address:** .....

**Telephone number:** .....

**Address:** .....

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