Evaluating an isiXhosa Clinical Communication course at a health sciences faculty

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DECLARATION

By submitting this thesis I, Madelé du Plessis, declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (save to the extent explicitly otherwise stated), and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Madelé du Plessis March 2017

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To my mom and dad: thank you for your tireless support and love during this time. Thank you for all the words of encouragement, for always sharing in my emotions, and for always making things easier for me during difficult times. Sharing this journey meant the world to me. I will forever be thankful for having you in my life.

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SUMMARY

For healthcare professionals the ability to communicate in the language of their patients is of prime importance. When language barriers between the healthcare professional and the patient occur, effective communication cannot take place, and, in turn, high quality care cannot be delivered. Many medical schools implement language programmes to equip students with the required language skills. However, these language programmes often tend to focus on language use in general situations, rather than focusing on clinical communication. Furthermore, these programmes do not necessarily comply with the requirements of the communicator competency of the CanMEDS framework. There is thus a need to evaluate the effectiveness of such language programmes. The aim of this study was to determine whether the isiXhosa clinical communication course implemented at Stellenbosch University Faculty of Medicine and Health Sciences is enabling students to communicate in the language of their patients. In addition, the research aimed to determine whether the communication course effectively contributes to the development of the communicator competency of the CanMEDS framework.

Data was gathered by means of individual interviews, questionnaires, observations, as well as document analysis. Two distinct populations were sampled, namely students and lecturers involved in the isiXhosa clinical communication course. The students included Occupational Therapy (third year) students, Human Nutrition (third year) students, and Speech-Language and Hearing Therapy (fourth year) students.

The findings indicate that the course material provided to students is not fully aligned with the requirements of the communicator competency. Therefore, students only have limited knowledge and vocabulary in isiXhosa. However, even though students have not acquired sufficient isiXhosa vocabulary and knowledge needed to communicate in a clinical context, they are still able to apply what they have learnt, enabling them to establish a positive relationship with patients.

Key words: clinical communication programme; communication; healthcare context; communicator competency; evaluate.

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OPSOMMING

Vir gesondheidsdeskundiges is dit belangrik om in die taal van hul pasiënte te kan kommunikeer. Taalstruikelblokke kan lei tot oneffektiewe kommunikasie tussen gesondheidsdeskundige en pasiënt, en gevolglik kan hoë kwaliteitsorg nie voorsien word nie. Terwyl verskeie mediese skole taalprogramme implimenteer om vir studente die nodige taalvaardighede aan te leer, dek hierdie taalprogramme meestal taalgebruik in algemene situasies, in plaas daarvan om op kliniese kommunikasie te fokus. Hierdie programme voldoen ook nie noodwendig aan die vereistes van die 'kommunikasievaardigheid' van die 'CanMEDS' raamwerk nie. Daar is dus die behoefte om die effektiwiteit van sulke taalprogramme te evalueer. Die doel van hierdie studie was om te bepaal of die isiXhosa kliniese kommunikasiekursus by die Universiteit van Stellenbosch se Fakulteit Geneeskunde en Gesondheidswetenskappe studente in staat stel om in die taal van hul pasiënte te kommunikeer. Hierbenewens het die studie ook ten doel gehad om te bepaal of die kommunikasiekursus effektief bydra tot die ontwikkeling van die 'kommunikasievaardigheid' van die 'CanMEDS' raamwerk.

Data is ingesamel deur middel van individuele onderhoude, vraelyste, observasies, asook dokumentanalise. Twee populasiegroepe is ingesluit, naamlik studente en dosente betrokke by die isiXhosa kliniese kommunikasiekursus. Die studente het Arbeidsterapiestudente (derdejaar), Dieetkundestudente (derdejaar), en Spraak-Taal en Gehoorterapiestudente (vierdejaar) ingesluit.

Resultate toon dat die kursusmateriaal wat aan studente voorsien word nie volledig in lyn is met die vereistes van die 'kommunikasievaardigheid' nie. Studente het dus 'n beperkte isiXhosa woordeskat en kennis. Al het studente nie voldoende kennis en woordeskat om in die kliniese konteks te kommunikeer nie, is hul steeds in staat om dít wat hulle geleer het toe te pas en sodoende 'n positiewe verhouding met pasiënte te ontwikkel.

Sleutelwoorde: kliniese kommunikasieprogram; kommunikasie; gesondheidskonteks; kommunikasievaardigheid; evalueer.

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LIST OF ACRONYMS

FMHS	Faculty of Medicine and Health Sciences
HN	Human Nutrition
IPE	Interprofessional Education
OT	Occupational Therapy
PBL	Problem-based learning
PPD	Personal and Professional Development
SBME	Simulation-Based Medical Education
SPH	Speech-Language and Hearing Therapy

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1 INTRODUCTION TO THE STUDY

1.1 Introduction

The aim of this chapter is to introduce the study of evaluating the isiXhosa communication course at the Faculty of Medicine and Health Sciences (FMHS), Stellenbosch University, implemented in the Departments of Speech-Language and Hearing Therapy, Human Nutrition and Occupational Therapy.

Communication is an important skill in the field of medicine and health sciences. Without effective communication skills, healthcare professionals are unable to effectively assist patients. It is thus necessary that healthcare professionals acquire communication skills in the language of their patients by means of effective communication programmes. This implies that language programmes should be reviewed and evaluated against the language needs of healthcare professionals. This project evaluated one such programme, namely the isiXhosa clinical communication course in the FMHS of Stellenbosch University.

Chapter 1 presents an overview of this specific project. Firstly, the term communication is defined and discussed. This is followed by a discussion of communication in the South African national context. Thereafter, the use of language in the Western Cape is explored, followed by a discussion of the importance of communication in a health professions context. Fifthly, an overview of the language situation at FMHS is given, after which the research problem is presented, followed by the research questions. After the limitations of the study are highlighted, a layout of the respective chapters is given.

1.2 Definition of communication

As a basic human need, communication is a very important part of the lives of people. It is central to the process of meaningful interaction among people. Communication can be defined as a process through which human beings try to reach shared understanding. Without the effective exchange of information, ideas, emotions and opinions among people, mutual understanding cannot be reached (Emanuel, 2007).

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Keyton (2011) defines communication as a process of conveying information and understanding from one person to another. The word 'communication' is originally derived from the Latin, *communis*, which means common. If common or mutual understanding does not result from the exchange of information, it means that communication is not effective, and in fact, that no communication has occurred (Cheney, 2011). Effective communication can be defined as communication that is understood by participants; it is normally a two-way process within which participants make meaning of the intended message (Schyve, 2007). Ultimately this means that in the ineffective communication leads to the absence of comprehension or misunderstanding.

In order to understand the complexity of communication, the basic process by which communication occurs needs to be analysed. When this process is understood, possible problems that could occur can be identified, and various ways of managing such breakdowns in order to enhance communication can be explored (Schyve, 2007).

As human beings are not considered to be passive and predictable 'objects' who always interpret meanings and react appropriately, communication is not a passive and predictable process. Communication is rather seen as an active process that is constantly affected and influenced by the complexities of human behavior. Clampitt (2005) advances the view that we constantly try to construct meanings in an active way by considering the words used, the context within which utterances occur, and the people involved. Communication can be viewed more accurately as a dynamic process in which aspects such as non-verbal behavior, individual styles of interpretation, and ascribing meaning to events play a significant role. In order to encourage effective communication, it is important to construct a clear, unambiguous message, and to make meaning by actively listening (Clampitt, 2005). In a multilingual context this complex process is even more challenging.

1.3 Multilingualism in the national context

South Africa is a multilingual country whose Constitution recognizes eleven official languages, namely Afrikaans, English, isiNdebele, isiXhosa, isiZulu, Sesotho sa Leboa, Sesotho, Setswana, siSwati, Tshivenda and Xitsonga. Besides these official languages, scores of other languages of African, European, and Asian origin are also spoken in the country, reflecting its truly diverse population composition. Examples of these languages include Sign Language, Arabic, German,

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Greek, Portuguese, Hindi, to mention but a few (Census, 2011; Lewis, Paul, Simons & Fennig, 2016). Generally, English is considered as the language that is most widely understood across the country, being the language of business, politics and the media, and generally being regarded as the *lingua franca* of the country (Lewis *et al*, 2016).

The fact that South Africa is such a linguistically diverse country means that the languages have had a profound effect on one another. For example, South African English contains words and phrases from Afrikaans, isiZulu, Nama, as well as other African languages.

According to the 2011 census (Census, 2011) isiZulu is spoken as mother tongue by approximately 22% of South Africans, isiXhosa as mother tongue is spoken by 16% of the population, Afrikaans by approximately 13%, English by 9.6%, Setswana by 8% and Sesotho by 7.6%. The remaining languages are vernacular to less than 5% of the South African population.

Most South Africans are multilingual, and are able to speak more than one language. There is a tendency among English- and Afrikaans-speaking people to not have the ability to speak other African languages, but they are most likely fluent in those two languages. Particularly in urban areas most South Africans speak English, which is omnipresent in official and commercial public life (Lewis *et al*, 2016).

Language diversity reflects the geographical spread of the country's population to a great extent. For example, isiXhosa is spoken by 80% of South Africans in the Eastern Cape, whereas it is spoken by only 25% of the population of the Western Cape. In the Western Cape, Afrikaans is the most spoken language (49.7%), followed by isiXhosa, with English in the third place (20.3%) (Census, 2011; Lewis *et al*, 2016). IsiXhosa is the second largest language in South Africa, spoken by 8 million South Africans (16% of the population). It is also a strong language in the Western Cape where 17% of all isiXhosa speakers live, forming nearly a quarter (25%) of the provincial population (Census, 2011; Lewis *et al*, 2016).

1.4 Language in the Western Cape

There are three official languages in the Western Cape, i.e. Afrikaans, English, and isiXhosa. It is evident from the abovementioned figures that isiXhosa is a relatively strong spoken language in this province, as isiXhosa speakers form nearly one quarter of the provincial population in the

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Western Cape. Contrary to Afrikaans- and English-speakers, the majority of isiXhosa speaking patients make use of public health care. Furthermore, very few isiXhosa speaking people are proficient in Afrikaans and/or English (Levin, 2011). On the other hand, many health care professionals have a limited level of Xhosa proficiency (Levin, 2011).

This means that the language capacity of healthcare professionals and patients vary greatly. A patient might understand enough of the healthcare professional's language to complete a form, but might not have enough vocabulary to understand the diagnosis and treatment options. In the same way, the healthcare professional might have basic vocabulary in the patient's vernacular to greet the patient and take his/her medical history, but might not have sufficient medical terminology to explain the diagnosis, or sufficient understanding of cultural nuances which can affect the meaning of words used (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003). Under these circumstances, due to language and cultural barriers, various communication errors might occur, resulting in less than optimal health care (Levin, 2011; Maseko & Kaschula, 2009). De Villiers (2011) argues that there is a positive correlation between health care and language, and where language barriers occur they will have a negative influence on health care.

Where language and cultural barriers exist, patients experience difficulties in understanding healthcare professionals, making themselves understood, and asking questions. This could result in patients blaming their own linguistic incompetence and limitations for inadequate healthcare, rather than that of the healthcare professionals. This also leads to numerous practical problems, such as healthcare professionals pronouncing isiXhosa names incorrectly which results in delays in the waiting room and patient anxiety (Levin, 2006). As a result of the above-mentioned factors healthcare professionals and patients are often obliged to interact with the help of an interpreter (Shlemmer & Mash, 2006).

1.5 Importance of communication in the health professions context

Healthcare professionals work with patients/clients in a variety of healthcare contexts (Reynolds, 2005; Parry, 2008), and communication is required when healthcare professionals enquire about health problems, discuss possible treatment, and manage the plan of treatment (Wynia & Osborn, 2010). Stewart (2001) advances the view that communication is more effective once it is responsive to the needs, values, and preferences of patients/clients (Almutairi, 2015).

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Establishing an empathetic connection between healthcare professional and patient/client is further dependent on the delivery of safe, high-quality care, and patient safety (Shohet, 2004; Cohen, Rivara, Marcuse *et al*, 2005). The inability of demonstrating patient safety will undermine the patient's trust in the quality of care (Flores, Rabke-Verani, Pine *et al*, 2002). A report on patient safety in Canada noted that substantial evidence exists that language (communication) is a significant predictor of the quality of care delivered (Flores, 2005). It is therefore important that patients/clients receive health services through competent and effective communication (Divi, Koss, Schmaltz & Loeb, 2007). To improve effective communication the healthcare professional and patient/client need to co-operate and co-ordinate their communication (Mauksch, Dugdale, Dodson & Epstein, 2008; Street, Gordon & Haidet, 2007).

It is firstly the responsibility of the healthcare professional to master effective communication as an essential skill. This includes having an awareness of the required communication features that should be present during consultations in order to build a positive relationship between healthcare professional and patient/client. Communication does not only rely on what is being said, but also on the way in which it is being said, incorporating both verbal and non-verbal skills (Roberts & Bucksey, 2007). In the context of health care, communication skills refer to being gentle when giving information, and emotional support through verbal behaviours such as greetings, open-ended and encouraging questions, and non-verbal behaviours such as facial expressions and gestures (Pinto, Ferreira, Oliveira, Franco, Adams, Maher & Ferreira, 2012). By improving their communication skills, healthcare professionals will be able to engage better with patients/clients by listening more attentively to what patients have to say, asking questions and also being sensitive to their emotional concerns. In this way, the participation of patients/clients will be facilitated and, in turn, patient-centred care will be enhanced (Pinto *et al*, 2012).

In recent years, patient-centeredness in medical education and in health professions education more generally, has gained importance (Härter, Van der Weijden & Elwyn, 2011). Patient-centred care aims to 1) put patients first in terms of their health and care, 2) ensure that patients make their own informed choices and decisions, and 3) develop a positive relationship between individuals and their families on the one hand and healthcare providers on the other. Patient-centred care incorporates key components such as self-management, shared and informed decision-making, an enhanced experience of health care, improved understanding, and the advancement of health

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promotion activities (British Columbia Ministry of Health, 2015). Effective communication plays a crucial role in patient-centred care, whereas on the other hand, language barriers leading to poor communication will result in patient dissatisfaction.

One of the ways to address the current language and cultural barriers in the South African health care context is to promote multilingualism among healthcare professionals by providing courses for additional language acquisition by these professionals. According to Maseko and Kaschula (2009) there are very few effective language programmes that equip student-professionals with communicative skills in the context of their profession. Where these language programmes do exist, they are generic in nature and usually focus on the structure of language and not on specific communication needs. The higher education system therefore produces health care professionals many of whom are communicatively incompetent in the languages of the patients/clients they serve (Maseko & Kaschula, 2009).

In order to address the current situation with regard to language and cultural barriers between healthcare professionals and patients/clients, it is important for health professions education to implement language curricula that contain content and communication skills specific to the needs of the students. The focus should be on communication in a clinical context in order to bridge the language and cultural barriers that are contributing towards constraining the provision of effective health care for all communities.

Due to the fact that learning a new language as an adult is not easy, it is important to create an environment in which students are able to acquire a basic understanding of the language of patients, as well as their culture (Schlemmer & Mash, 2006). The idea is not to be fully bilingual/multilingual; it is rather to provide healthcare trainees with the necessary knowledge and vocabulary in order to be able to communicate with their patients/clients.

1.6 Language at the Faculty of Medicine and Health Sciences, Stellenbosch University

As one of the nine medical schools in South Africa, the Faculty of Medicine and Health Sciences (FMHS) at Stellenbosch University aims at, amongst other things, developing communication skills of students in order to meet the needs of patients in a diverse society. To create a diverse work force in the health sciences, as well as competency within the health sciences work

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environment, healthcare professionals should be trained to effectively communicate with colleagues and the health team concerned, as well as with patients/clients.

As discussed in Section 1.5, it is evident that healthcare professionals' communication in the language of patients/clients has a positive effect on the quality of health care. Therefore, it is important to include the three official languages of the Western Cape, i.e. Afrikaans, English and isiXhosa, in the curriculum of the FMHS. Developing communication skills in the health sciences context further contributes to the personal and professional development of healthcare professionals.

Professionalism in the health sciences includes competency in clinical skills, but covers a wider spectrum as well. This is illustrated by the CanMEDS Roles Framework initiative, developed by the Canadian Royal College of Surgeons and Physicians, and implemented and applied to guide medical education globally (Frank, 2004). FMHS has also implemented the CanMEDS framework, though in a modified form. The Undergraduate Education and Training Subcommittee of the Medical and Dental Professions Board in collaboration with training institutions and the South African Committee of Medical and Dental Deans have adapted the core competencies from the CanMEDS framework for undergraduate students. This adapted framework was accepted by the Health Professions Council of South Africa (HPCSA), hence all the undergraduate programmes at FMHS have to incorporate the CanMEDS framework in their curriculum. The CanMEDS framework identifies the overarching profile of the healthcare practitioner as the interconnection of six core competencies that would enable the healthcare professional to meet the needs of society. These six competencies include the Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional (Frank, 2004) (refer to Chapter 2 for further discussion). For this study the communicator competency is of particular importance.

According to CanMEDS, health professionals as communicators should effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter. This is, of course, complex in multilingual societies, particularly when the same language of communication is not shared by health care workers and patients. This project will specifically focus on how the communicator competency of the CanMEDS framework can be improved (if at all) by an isiXhosa language course for undergraduate allied health professions (Speech-Language and Hearing Therapy, Human Nutrition, Occupational Therapy) students.

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1.7 Research problem and research questions

Few language programmes effectively equip student-professionals with communicative skills in the context of their profession (Maseko, 2007b). Where these programmes exist, they are mostly generic language programmes focusing on the structure of the language, and not on the specific communication needs of the students. Research has shown that students trained in South African institutions of higher learning are not able to cope in South Africa's multilingual and multicultural environment due to the fact that they cannot effectively provide services to the majority of the people they are supposed to serve, i.e. African language speakers (Maseko, 2007b; Maseko & Kaschula, 2009). There is, however, a growing awareness of the need to develop and review curricula in accordance with the changing needs of multilingual communities (De Klerk, 2002).

In 2012, FMHS embarked on a new initiative, namely the inclusion of an isiXhosa clinical communication course in undergraduate programmes. This isiXhosa clinical communication course was specifically implemented in the Division of Speech-Language & Hearing Therapy, the Division of Occupational Therapy, the Division of Physiotherapy, and the Division of Human Nutrition. The content of the isiXhosa course is specific to the needs of each of the respective undergraduate programmes. In this particular approach, the focus is on learning how to communicate in a clinical context in the target language, i.e. isiXhosa, in order to bridge the language and cultural barriers and, in turn, improve health care. The focus is also on developing students' isiXhosa language proficiency. In order to do this, the classroom setting is communication-based where students have the opportunity to engage in 'real life' situations. This initiative aims at providing innovative language and communication interventions for health practitioners to: 1) improve patient quality of care; 2) promote multilingualism amongst health care professionals; and 3) facilitate change in the health care environment.

This research study is intended to explore students' experiences of the isiXhosa clinical communication course implemented at FMHS, specifically in the abovementioned programmes. The aim is also to investigate students' communicative competence after completion of this course. Furthermore, this study will evaluate the above isiXhosa clinical communication course in order to determine whether they effectively contribute to the development of the communicator competency as spelt out in the CanMEDS framework (adapted to the Stellenbosch University Faculty of Medicine and Health Sciences).

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From the research problem described above, the following main research question ensued:

To what extent does the isiXhosa clinical communication course of the Faculty of Medicine and Health Sciences at Stellenbosch University in Speech-Language and Hearing Therapy, Human Nutrition, and Occupational Therapy satisfy the communicator competency requirements of the modified CanMEDS framework?

The following sub-questions were investigated to answer the main question:

Sub-question 1: To what extent does the course documentation of the current isiXhosa clinical communication course provide evidence of meeting the requirements of the modified CanMEDS communicator competency?

In order to answer this sub-question a document analysis of the module objectives, outcomes, course outlines and other relevant documentation was performed.

Sub-question 2: What are students' perceptions of the extent to which the isiXhosa clinical communication course equips them to meet the requirements of the CanMEDS communicator competency?

Student perceptions were investigated by means of a student survey, which was followed by focus group discussions that were conducted according to the specialist areas of the students.

Sub-question 3: To what extent are lecturers of the isiXhosa clinical communication course attempting to meet the requirements of the modified CanMEDS communicator competency?

For this purpose staff members in the isiXhosa clinical communication course were interviewed.

Sub-question 4: To what extent do observations of clinical consultations of students in the course provide evidence of meeting the requirements of the modified CanMEDS communicator competency?

Occupational Therapy students, Human Nutrition students, and Speech-Language and Hearing Therapy students in consultation with patients were observed in simulation.

All the information gathered from the sub-question contributed towards answering the research question.

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1.8 Limitations of the study

A limited number of students and lecturers could be used for the purpose of this project. Three groups of students (n = 58) and one group of staff (n = 2) participated in the study. The student groups included third-year Human Nutrition (n = 26) students, third-year Occupational Therapy (n = 25) students, and fourth-year Speech-Language and Hearing Therapy (n = 7) students.

Due to logistical and ethical challenges, students had to be observed with patients while in simulation and not in 'real life' contexts. Logistically, it was challenging for the researcher to be able to sit in on patient consultations in order to observe the communication process between healthcare professional and patient. Ethically, the researcher as an outsider would have intruded in the relationship between healthcare professional and patient, and this might have influenced the communication process. Furthermore, it would have been ideal to observe students more than once, but due to logistical and time constraints this could not be done and thus students were only observed once.

1.9 Chapter layout

The rest of the thesis is structured as follows: Chapter two provides a brief overview of health professions education and training in an international context, followed by an overview of medical training in South Africa, and medical training at FMHS with a specific focus on the implementation of the CanMEDS framework and how it contributes towards the profile of health professionals.

Chapter three investigates communication as a critical skill of a healthcare professional. The challenges of a healthcare professional with regard to communication will specifically be explored. This is followed by an argument for the implementation of a language programme as one possible way of addressing communication barriers and language difficulties in health professional practice. An overview of isiXhosa clinical communication course in Speech-Language and Hearing Therapy, Human Nutrition and Occupational Therapy at FMHS is provided.

In Chapter four, the research methodology and research design are discussed. Chapter five presents the research results. In Chapter six, conclusion are drawn and recommendations made.

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2 HEALTH PROFESSIONS EDUCATION AND TRAINING

2.1 Introduction

Seeing that the focus of this study is the acquisition of communication competence in isiXhosa by health professions graduates of Stellenbosch University, the aim of this chapter is to provide an overview of health professions education and training internationally, in South Africa, and at Stellenbosch University Faculty of Medicine and Health Sciences (FMHS). It will cover epistemology and pedagogy in health professions education, and the CanMEDS Framework internationally. Thereafter, reforms in health professions education in South Africa, as well as the key elements that inform health professions education and training in South Africa will be discussed. Following this discussion, the profile of the 'Stellenbosch healthcare worker' will be described. Finally, the structure within which language courses for allied health professions programmes at FMHS occur will be presented. Even though this study's focus is particularly on allied health professions, a broader overview of health professions education and training will be provided due to the fact that allied health professions training is part of the broader field of health professions education, and very little has been published in the narrower field of allied health professions training.

2.2 Overview of health professions education and training internationally

Health professions education and training provides health professions students with the opportunity to develop a wide spectrum of knowledge and clinical skills through a variety of learning experiences. The delivery of healthcare and treatment by health professionals are concerned with both quality and accountability. For this reason, there is a need for healthcare professionals to critically review their knowledge and skills, and to keep up to date with changes in practice (French & Dowds, 2008).

Health professions education include three sectors, namely undergraduate, postgraduate, as well as the continuation of professional development of the healthcare professionals. The aim of health professions education is to develop knowledgeable, skilled and 'up-to-date' healthcare professionals who will be able to make patient care priority, as well as develop their expertise during the period of their career (Swanwick, 2014). Due to the fact that health professions

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education has a privileged position in society, it is set apart from the main stream of higher education. In many countries it happens that health professions education has separate funding, is a beneficiary of status, and is considered a powerful and 'conservative, political lobby' (Swanwick, 2014).

Swansick (2014: 3) argues that the discipline of health professions education lies "within the confines of this academic and political preserves". It is however questionable whether health professions education is a discipline in its own right, or whether it is an idiosyncratic collection of concepts which are derived from other educational fields (Whitehead, 2013). It is a definite that various educational assumptions such as experiential learning, reflective practice, and certain curricular approaches have been borrowed from other educational fields. However, health professions education make its own significant contributions towards the wider spectrum of higher education. A few of these developments include, for example, problem-based learning, simulation, structured assessments of clinical competence, supervision, and the use of technology in order to enhance learning (Swanwick, 2014).

Furthermore, it can be argued that health professions education is "in a perpetual state of unrest (Cooke, Irby, Sullivan & Ludmerer, 2006: 1339). In other words, health professions education constantly urge reform. Therefore, health professions education is complex, contested, and very political. In a complex environment it is necessary to make the best decisions regarding education, training, and clinical development (Swanwick, 2014).

Continuous Professional Development (CPD) is thus central to this process. Three functions of CPD can be identified: 1) the notion of lifelong learning (maintenance role), 2) practitioners demonstrating ongoing competence (survival role), and 3) the increase of employability (mobility role) (Sadler-Smith, Allinson & Hayes, 2000).

CPD includes areas of personal and professional development which should start during undergraduate health professions education. Personal and professional development incorporates aspects of clinical proficiency, and also non-clinical aspects such as management, leadership and communication skills (Cooney & Blake, 2000).

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Furthermore, personal and professional development also entails epistemological beliefs, and therefore it is important to understand and integrate these beliefs into the teaching and learning of medical and healthcare professionals (Golberg, 2000; Bientzle, Cress & Kimmerle, 2014).

2.2.1 Epistemology in health professions education

For healthcare professionals to master their respective tasks, it is important to consistently form judgments regarding the veracity of health sciences knowledge. This arises from the fact that knowledge in the health sciences field is widespread, comprehensive, fast-developing, and includes a lot of ambiguous and tentative information (Kienhues, Stadtler & Bromme, 2011). The way in which healthcare professionals deal with health knowledge is critically influenced by their epistemological beliefs (Knight & Mattick, 2006). Epistemological beliefs "are the cognitions (i.e. understandings) individuals have on knowledge and knowing and determine how (new) knowledge is perceived and processed" (Roux & Degryse, 2007: 616). Epistemological beliefs are closely linked to the domains of education such as learning, motivation, reasoning and performance (Muis, 2004).

Epistemological beliefs, including individual beliefs and presuppositions about knowledge and learning, play an important role in any type of education. In health professions education this includes not only students' beliefs regarding knowledge and the way they approach their learning strategies, but also the way they should practice their profession (Pena, Paco & Peralta, 2002). Understanding how healthcare professionals evaluate knowledge in their own discipline is important, as healthcare professionals often work in interdisciplinary teams (Bientzle, Cress & Kimmerle, 2014).

When focusing on language acquisition by healthcare professionals, it is important to consider the relationship between students' personal epistemologies, their choice of learning strategies and the intended learning outcomes in terms of the acquisition of language and communication skills in the healthcare context (Ioana, 2014). Importantly, the success of language courses leading to the acquisition of language and communication skills heavily depends on internal factors such as students' cognitive and affective dispositions. According to Stevick (1980), acquiring language and communication skills is more dependent on internal processes than on teaching materials and teaching methods.

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A study done among Romanian healthcare students confirmed that students prefer developing a contextualised conception of knowledge and learning, while teachers' teaching style does not foster ambiguity "and not straying too far from associating being a good student with memorization" (Ioana, 2014:3 616). Considering the link between general epistemic beliefs and the beliefs about language learning, it is clear that students favour different types of learning. Some students favour memorization, other students appreciate the importance of language practice, while others with a more simplistic view of knowledge regard grammar as an important aspect of language learning. Understanding these preferences and learning styles "allows for a more effective and empowering pedagogy, especially when language is being studied for professional purposes" (such as the healthcare profession) (Ioana, 2014: 3610).

2.2.2 Pedagogy in health professions education

Different learning theories, particularly cognitive learning theories, have enabled a better understanding of how students gain health professions expertise (Kaufman, 2003). Understanding learning and trends in the design of medical curricula has an impact on the design of effective courses and the delivery thereof in various settings, including the clinical setting (Barrow, McKimm & Samarasekera, 2010). It is clear that students learn more effectively if instruction is systematically organised, objectives are well defined, the educational opportunities provided are appropriate for the students' level of intellectual development, and the acquisition of skills takes place within the context in which it is to be applied (Woolley & Jarvis, 2007). It is also important that students have the opportunity to actively build on their knowledge and skills by means of interplay between existing expertise and new experiences. In addition, students should have sufficient opportunities to consolidate their newly acquired skills and knowledge by practice in a variety of healthcare environments (Conn *et al*, 2012).

During the past decade, patient care has started focusing more on chronic disorders and how they are managed in the community, rather than on acute conditions (Duckett, 2007). This shift means that a variety of healthcare professionals working across diverse settings are needed. One of the major challenges in such a scenario is poor communication and collaboration between healthcare professionals involved (Olson & Bialocerkowski, 2014). To address these aspects in the healthcare setting, interprofessional education (IPE) is introduced into medical, as well as allied health

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professions education. Interprofessional education involves students from different health-related professions learning from and about each other. The aim is to improve collaboration, effective communication, and, in turn, provide better patient/client care (Henderson, O'Keefe & Alexander, 2010). Due to the fact that Competency-based Education (CBE) (see section 2.2.3) aims to prepare healthcare professionals for practice (Ten Cate, 2014), this is also considered an important aspect in health professions education.

To create a variety of healthcare environments that allow for students' practice is one of the reasons why simulation was integrated into health professions education. Simulation-based medical education (SBME) ensures that a variety of learning opportunities are created in a clinical setting. Not only does SBME create various learning opportunities, but it also establishes a safe learning environment in which mistakes can be made without them being harmful. SBME enables a powerful learning experience in a controlled environment (Kalaniti & Campbell, 2015)

There are several learning theories underpinning simulation-based learning. According to adult learning theory, adults tend to be internally motivated and self-directed, and thus need to know why they are learning (Bryan, Kreuter & Brownson, 2009). SBME, reflecting real-life situations in the learning environment, makes provision for relevance in health professions education. Kolb's (1986) theory of experiential learning emphasises the concept of 'learning by doing' and regards learning as a process of building on concrete experiences. SBME provides an opportunity of applying this learning theory. It is important to realise that the best way to facilitate skills acquisition is to focus on learning, rather than on teaching (Halamek, 2007).

Not only is effective health professions education important, but also effective assessment and feedback. Effective assessment and feedback are important for the development of reflective practice, as well as to enable students to learn how to analyse their own performance and to identify their individual learning needs (Mamede & Schmidt, 2004). Teachers and students have a combined responsibility to enhance the effectiveness of acquiring knowledge and skills (Conn, Lake, McColl, Bilszta & Woodward-Kron, 2012).

Clinical education forms part of the curriculum in health professions education to enhance the effectiveness of acquiring knowledge and skills. Clinical education in the health professions involves the interplay of setting, instructor, and student. Furthermore, clinical education involves

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both theoretical and practical educational components which are integrated into real life situations with actual patients (Jarski, Kulig & Olsen, 1990; Weidner & Henning, 2002). Clinical education progresses from the general technical skills which students gain to clinical competence, and it is thus important that students develop the necessary interpersonal and social skills, as well as attitudes (Weidner & August, 1997; Weidner & Henning, 2002).

Teaching and learning in health professions covers a wider spectrum than only competency in clinical skills. Apart from having clinical skills, healthcare professionals should also be able to work together within a team, be lifelong learners and contribute their knowledge to improve health, be ethical in their behaviour, and have the ability to effectively communicate with patients in order to establish a positive relationship (Halamek, 2007).

Effectively communicating in a healthcare context requires sufficient communication skills. Communication skills training has been accepted as an important aspect of health professions education. However, integrating communication skills with other clinical skills proved to be rather challenging. Learners specifically experienced problems when confronted with two conflicting models, i.e. a communication model which describes the process of an interview between healthcare worker and patient, and a traditional history model which describes the content needed. To address these difficulties a comprehensive method, namely the Calgary-Cambridge guides, was introduced that integrates the traditional clinical method with effective communication skills (Kurtz, Silverman, Benson & Draper, 2003). Through integration of process and content, information can be elicited about both the healthcare problems and the perspectives of the patients. Furthermore, the Calgary-Cambridge guides makes it easier for learners to conceptualise how communication skills and the physical examination work together in an integrated manner (Kurtz, Silverman, Benson & Draper, 2003).

The intention is also to be able to transfer the communication skills learnt from the classroom setting into work-based placements (Stoneham & Feltham, 2009). To enhance this process, role-play has been used as a teaching and learning tool. Johnson and Johnson (2000) advance the view that role-play is important for learning and mastering new skills. Four qualities of role-play can be identified, namely 1) experience the situation concretely, 2) identify effective and ineffective behaviour, 3) gain insight into this behaviour, and 4) practice the skills required in order to manage the situation constructively (Stoneham & Feltham, 2009). Role-play is advantageous due to the

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fact that experience provides evidence on which one can reflect. By reflecting on the experiences, general principles can be developed which, in turn, inform how learning can be transferred to different contexts (Stoneham & Feltham, 2009).

Role-play, as well as the use of simulated patients, is often used in health professions education to practise clinical communication skills by providing a bridge between theory and practice. According to Kurtz *et al*. (2005: 88) "simulated patients have been used successfully in communication skills teaching, evaluation and research" (the use of simulated patients will be further discussed in Chapter 3).

From the above it is clear that the clinical environment remains a key area for acquiring communication skills (Rostami & Khadjooi, 2010). During the process of learning it is important to identify principles of learning, as well as to understand how individual differences can affect the learning process. It also important to recognise different learning styles.

Continuous changes in clinical practice, as well as within health professions education and the need for the acquisition of the abovementioned skills have led to the development and implementation of the CanMEDS Roles Framework initiative. Changes in the healthcare system over the past fifty years are no longer compatible with the type of healthcare professionals trained. It would seem that after training, healthcare professionals become practitioners with a decreased common identity, common practice, common language, and also a common understanding of problems experienced by patients/clients. Diagnostic and therapeutic options in healthcare systems have increased in such a way that more collaboration and communication are required (Touchie & Ten Cate, 2015). It is thus important to ensure the acquisition of the various competencies as outlined by the CanMEDS framework.

The CanMEDS framework will next be discussed both in an international context, as well as within the context of FMHS.

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2.2.3 CanMEDS framework

In the early 1990s Fellows of the Royal College of Physicians and Surgeons of Canada, with support from the Associated Medical Services, developed a competency framework, i.e. the CanMEDS framework, for specialist physicians. The CanMEDS framework was formally accepted and approved by the Royal College in 1996, and subsequently updated in 2005. This framework describes the key abilities needed for a healthcare professional to optimally meet the health care needs of the population, and it is globally implemented and applied to guide medical education (Frank, Snell & Sherbino, 2015; Frank & Vanoss, 2007; Richardson, Calder, Dean *et al*, 2014).

In Canada, the CanMEDS framework forms the basis for educational standards and medical training. The College of Family Physicians of Canada has integrated an adaptation of the CanMEDS framework into the training of family physicians, known as CanMEDS-FM (CanMEDS – Family Medicine). It has also been adopted and implemented by the Medical Council of Canada, the Canadian Medical Association and Canada's medical schools. Today, the CanMEDS framework is recognised as the most widely applied competency framework in medical education due to the fact that it has been implemented in many countries globally, both in medicine and in other health care professions (Frank *et al*, 2015).

The CanMEDS framework identifies the overarching profile of the medical expert as the interconnection of six core competencies that would meet the needs of society (see Figure 2-1). These six competencies include the Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional (Frank, 2004; Chhem, Samson, Frank & Dubois, 2009). The communicator competency will further be discussed in Chapter 3 as communication is the focus of this study. Also refer to Addendum A for a description of the six core competencies, as well as the overarching profile of the healthcare practitioner.

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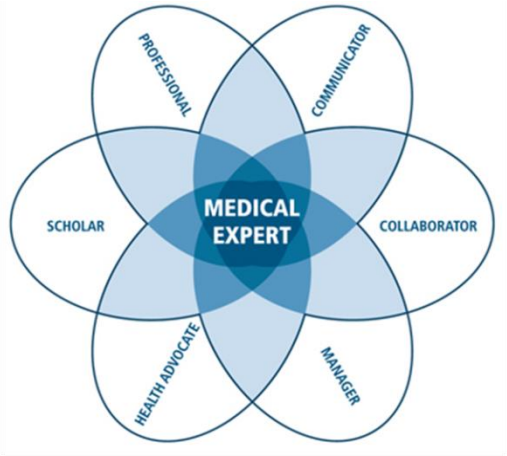

Diagram illustrating the seven CanMEDS Roles and their interconnection
(Royal College, 2001)

Figure 2-1: Seven CanMEDS roles and their interconnection (Frank, 2004)

The implementation of the CanMEDS Framework can enable healthcare professionals to acquire the necessary competencies needed to meet the healthcare needs of patients/clients, because it enhances competency-based education and training. Competency-based education (CBE) can be defined as education that aims to meet a certain level of proficiency in one or more competencies (Ten Cate, 2014), as well as a means of preparing healthcare professionals for practice which is based on graduate outcome abilities and also competencies derived from patient/client needs (Frank, Mungroo, Ahmad, Wang, De Rossi & Horsley, 2010). Competency-based education thus requires two core elements, namely 1) redefining what a competent healthcare professional is, and 2) focussing on the training of competent graduates (Touchie & Ten Cate, 2015).

2.3 Health professions training in South Africa

Currently, there are nine medical schools in South Africa, namely Walter Sisulu University, University of Witwatersrand, University of Free State, University of Pretoria, University of KwaZulu-Natal, Sefako Makgatho Health Sciences University, University of Cape Town, University of Limpopo, and University of Stellenbosch. Each of these respective universities offers the following undergraduate allied health professions education: At Walter Sisulu University there are degrees in Health Promotion and Social Work. The health science faculty at the University of Witwatersrand offers Occupational Therapy and Physiotherapy. At the University of Free State

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there are Occupational Therapy, Dietetics, Physiotherapy, Optometry, and Biokinetics. The University of Pretoria offers Dietetics, Occupational Therapy and Physiotherapy. University of KwaZulu-Natal has Occupational Therapy, Physiotherapy and Speech-Language Pathology, while Sefako Makgatho offers Physiotherapy, Speech, Hearing and Sight, Dietetics and Nutrition, as well as Occupational Therapy. The University of Cape Town offers Physiotherapy, Occupational Therapy, and Speech-Language Pathology, while Stellenbosch University offers Physiotherapy, Speech-Language and Hearing Therapy, Human Nutrition, and Occupational Therapy. A few other Higher Education institutions also offer health sciences programmes, for example, the University of Western Cape (UWC) offers Physiotherapy, Nursing and Dentistry, and Cape Peninsula University of Technology (CPUT) offers Nursing.

In South Africa, as in other countries, the traditional teacher-centred, lecture-based medical education of the 20th century has changed to a more student-centred, problem-orientated, and community-based approach in the 21st century (Jackson & Calman, 2006). One of the reasons for these changes was the fact that healthcare professionals were expected to acquire clinical reasoning skills, and the ability to review and integrate research findings (Tavakol & Reicherter, 2003).

Problem-based learning (PBL) is an effective method to enhance student-centred teaching and learning in medical, as well as other health professions education and training. PBL is dependent on self-directed learning, stems from clinical problems, and provides a learning environment fostered by active inquisition. Instead of the lecturer being the giver of information, the focus is rather on the learning process, and students are responsible for their own learning (Wetzel, 1996; Tavakol & Reicherter, 2003). In PBL programmes the principal tasks for students include group discussions regarding specific case studies, raising questions, proposing hypotheses, searching for and presenting information, and teaching each other. This process of PBL has been effective in terms of integration of knowledge, as well as interdisciplinary collaboration (Tavakol & Reicherter, 2003).

A combination of PBL and traditional teaching methods can be implemented, which is referred to as the transitional model. The transitional model of teaching integrates traditional, subject-based courses during the early phase of the curriculum after which the clinical problem scenarios phase is introduced (Tavakol & Reicherter, 2003).

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Due to the fact that student learning in the higher education environment is an active and constructive process the so-called 'SPICES model' is often used in the teaching and learning process. The term SPICES is an acronym for six strategies (student-centred, problem-based, integrated, community-based, electives, systematic) which can be used in curriculum planning and development (Harden, 2000; Changiz & Yousefy, 2006). It is important to create an environment in which students are able to actively engage with the particular subject matter in order to understand and learn it. For this reason, constructive alignment between the subject matter and the environment created is important.

Constructive alignment is an approach used to enhance quality learning. Usually, constructive alignment starts with the notion that students construct their own learning by means of relevant learning activities. A learning environment should thus be created accordingly in order to support the learning activities which are appropriate to the desired learning outcomes (Biggs, 2003). Therefore, to set up an aligned system, the following steps should be followed: firstly, the desired outcomes of teaching in terms of content, as well as the level of understanding must be defined, after which an environment must be created in which students will have the ability to engage in activities which are designed to achieve the intended outcomes. Finally, applicable assessments should be chosen reflecting the extent to which students have reached the outcomes (Biggs, 2003).

Developing critical thinking, reflective, and problem solving skills is a vital aspect of student learning in a clinical context as they work with different patients experiencing different situations. Creating effective contexts in which students are able to acquire these skills is thus necessary (Hattie, 2010).

People tend to learn easier when they "acquire new information, develop and practice new skills, reconfigure what they already know, and recognise what they have learned" (Grunert, Millis & Cohen, 2008: 4). Students' perspectives and the way they see the world need to be changed. This change includes acquiring information constructively, as well as applying the newly acquired information effectively (Biggs & Tang, 2007).

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2.3.1 Reforms in health sciences education in South Africa

The causes of the poor health status, i.e. the healthcare of the population in South Africa is most probably experienced as multi-factorial; however, it is important that education and training of healthcare professionals is aligned with the society's health needs (Van Heerden, 2013).

During the past century three generations of reforms in health sciences education in South Africa characterized progress in this regard. These reforms are a challenging process which still needs to be implemented to their fullest consequences. The first generation, which was launched at the start of the 20th century, put a science-based curriculum in place. Following this, the second generation introduced a problem-based instructional medical curriculum. After having both a science-based and problem-based curriculum, a third generation was introduced, namely systems-based curriculum. Being system-based, the curriculum adapted core professional competencies to specific contexts, while drawing on global knowledge. In order to enhance these third generation reforms, health care professionals have been taught to mobilise knowledge, to engage in critical thinking, as well as ethical conduct in order to optimally participate in patient-centred healthcare systems. This was materialized through guiding health sciences education to achieve two proposed outcomes, namely transformative learning and interdependence in health sciences education (Frenk *et al*, 2010).

Before transformative learning, training institutions mainly focused on informative and formative learning. Informative learning "refers to the learning of facts and skills and produces a technical expert" (Van Heerden, 2013: 21). On the other hand, formative learning "exposes the student to the elements required to become a professional, i.e. ethical norms, professional behavior, etc" (Van Heerden, 2013: 21). However, these approaches to learning lacked a systems perspective. The key driver of health sciences education should be 1) the needs of the population, and 2) the needs of the health system. When these two aspects inform the competencies necessary for medical graduates to acquire, they should also inform the outcomes, content and design of the curriculum. Based on these requirements transformative learning was introduced. Transformative learning "facilitates the development of change agents that will help ensure that the population's health needs are met, that inequities are minimized, and that health system deficiencies are addressed in co-operation with the relevant stakeholders" (Van Heerden, 2013: 21).

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In addition to transformative learning, interdependence also grew in importance in health sciences education. Interdependence refers to the need for healthcare professionals from various healthcare professions to be able to collaborate with one another. It further refers to the education and health systems training of healthcare professionals to address the needs of the population by being globally connected (Van Heerden, 2013).

2.3.2 Key elements informing health sciences education in South Africa

In 2011, the Medical and Dental Professions Board (MDB) together with their Undergraduate Education and Training (UET) subcommittee reviewed the situation of health sciences education and training in South Africa in an attempt to inform future accreditation policy and processes. Representatives from all relevant South African institutions responsible for the training of health care professionals also reviewed their health sciences education and training. Subsequently five key elements were identified that should inform the training of health care professionals in the future. They include the following: 1) competency-driven instructional design; 2) the ability of graduates to work effectively in inter- and trans-professional teams; 3) the ability of graduates from various professions to share tasks where appropriate and needed; 4) the willingness of training institutions to share open educational resources; and 5) the willingness to engage with other stakeholders in health and education systems to optimize collaboration (Van Heerden, 2013).

It was agreed that the abovementioned elements were acceptable and achievable in the South African health care context. Clearly 21st century reforms cannot be followed through with outdated or even inadequate competencies. Therefore, core competencies based on transnational, multi-professional, and long-term perspectives were developed in order to serve the health needs of the population (Frenk *et al*, 2010). As described in section 2.2.3, a core competency framework, namely the CanMEDS framework, for health care was developed. This CanMEDS framework was adapted in order for the key and enabling competencies to be applicable to education and training of health professionals in a South African medical context (Van Heerden, 2013). More specifically, the CanMEDS framework was used to inform undergraduate health sciences education, as well as the allied health professions training at Stellenbosch University's Faculty of Medicine and Health Sciences.

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2.4 Health sciences training at Stellenbosch University Faculty of Medicine and Health Sciences (FHMS)

At FMHS the Centre for Health Professions Education (CHPE) has been engaged together with the various undergraduate programmes in refining the attributes that students are expected to demonstrate in the health care sector once they have graduated. For this purpose an amended version of the CanMEDS framework was adopted. The aim of the CanMEDS framework is to guide education and training in the FMHS that would equip students with the necessary skills needed in order to address the health inequalities through patient-centred and community-based care (Centre for Health Professions Education, 2014).

The CanMEDS competency framework of the Royal College of Physicians and Surgeons of Canada was taken as the point of departure, and a number of months were spent on adapting the framework to the South African context. The adapted framework stated that students graduating from FMHS must be competent to fulfill and demonstrate seven roles enabling them to meet the health needs of our country, namely Healthcare Practitioner, Communicator, Collaborator, Leader and Manager, Health Advocate, Scholar and Professional. In the CanMEDS framework adapted for FMHS, 'Medical Expert' was changed to 'Health Practitioner'. Furthermore, the key and enabling competencies were adapted for undergraduate training, applicable in all five undergraduate training programmes (i.e. Medicine, Occupational Therapy, Human Nutrition, Physiotherapy, and Speech-Language and Hearing Therapy), and for the local context. In 2013, the Faculty Board accepted the final framework for all undergraduate programmes. The graduate attributes were integrated into the various undergraduate curricula.

The integration of these core competencies starts, for example, in the Inter-professional Phase in the first year when Medical, Physiotherapy and Human Nutrition students follow a module on Health in Context. The purpose of this module is to teach students how to integrate the graduate attributes in their learning during their period of study. In this particular module, students are expected to choose a specific community and research the social determinants of health impacting on the health of the chosen community, as well as the functioning of the health system. During this process, various graduate attributes in the Faculty's framework are developed and assessed.

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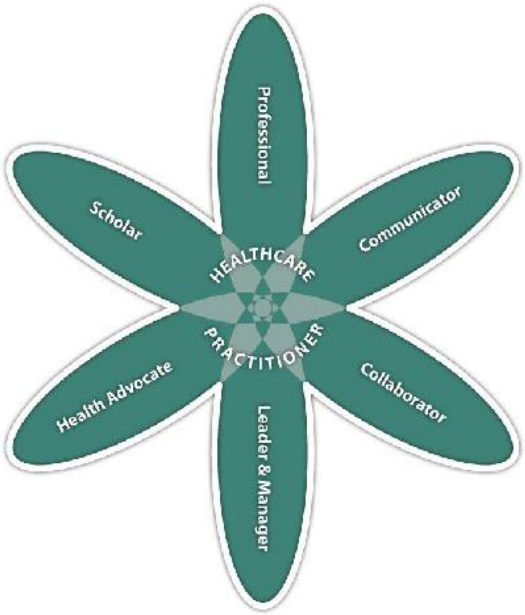

Diagram illustrating the seven CanMEDS roles and their interconnection implemented at FMHS

Figure 2-2: Seven CanMEDS roles and their interconnection (Frank, 2004) (Adapted from the CanMEDS Physician Competency Framework)

2.4.1 Profile of the 'Stellenbosch healthcare provider'

Determining whether healthcare professionals are competent is important. Competence refers to a healthcare professional's suitability for a specific discipline and is focused on the knowledge, skills and attitudes of a healthcare professional (Mentkowski, 2000). Achieving competence is a developmental process which requires gradual progression towards the integration of the acquired knowledge, skills and attitudes (Zane, 2008). Competency-based education focuses on what learners need to know and be able to do (outcomes), in view of the goals of the programme. In this light, competencies define the knowledge, skills and attitudes required to enable healthcare professionals to optimally function within a specific discipline (Lichtenberg, Bebeau, Nelson, Smith, Portnoy & Leigh, 2007).

Integrating the graduate attributes into the undergraduate programmes at FMHS enables students to acquire the knowledge, skills and attitudes needed to optimally function within the healthcare sector. For purposes of this study, only the knowledge, skills and attitudes of Occupational Therapy students will be described due to the fact that there is no document currently available for Human

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Nutrition and Speech-Language and Hearing Therapy describing the knowledge, skills and attitudes in their context.

The knowledge, skills and attitudes required of a Stellenbosch Occupational Therapist include the following (Division of Occupational Therapy, Stellenbosch University, 2013):

Knowledge

Thorough knowledge of all relevant knowledge contents, as well as extensive career-specific knowledge, including:

- Basic, pre-clinical and clinical content
- Knowledge of health, the progression of illness and the influence of illness on function
- The bio-psychosocial client-centred approach
- The philosophy of participation in activities ("occupational performance") as a medium for treatment
- Knowledge of the analysis of activities to be able to make adaptations in relation to the needs of the client in all spheres of his/her daily tasks and specific circumstances
- Knowledge of the management of activities, people and resources in occupational therapy practice
- Knowledge of contextually relevant approaches to the treatment of individuals and groups

Skills

Through clinical deliberation, the skill to integrate and interpret knowledge, and apply it with self-confidence in all environments in order to contribute to the optimal functioning of the patient/client by means of:

- Being able to select and implement relevant approaches to treatment
- Providing justifiable direct and indirect occupational therapy services
- Effective execution of preventative, promotive, therapeutic and rehabilitative occupational therapy programmes
- Empowering the patient/client to take responsibility for his/her own health

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- The initiation and effective management of occupational therapy services in a team context during primary, secondary and tertiary preventative programmes
- Research that contributes to the extension of the scientific knowledge base of the career

Attitudes

Positive attitude that places the well-being of the patient/client foremost by means of:

- The maintenance of the professional and ethical standards of the profession
- Acknowledging and showing respect for the diversity of clients within diverse, multicultural communities
- The attitude that learning is a lifelong activity, including a positive attitude to continuing professional development

In order to effectively apply the necessary knowledge, skills and attitudes, it is important to effectively engage with both patients/clients and other healthcare professionals within the health care context. Furthermore, communication skills are not only regarded as one of the skills of the profile of a Stellenbosch healthcare professional; they also determine the way in which healthcare professionals understand and construct knowledge. Furthermore, communication skills determine how healthcare professionals will apply skills such as being professional in their ability to develop relationships with patients/clients, elicit information and perspectives of patients/clients, convey information and explanations to patients/clients, and to develop a common understanding on problems with patients/clients in an attempt to develop a shared plan of care.

The development of effective communication skills, including language acquisition, is an important part of becoming a good healthcare professional (Kurtz, Silverman, Benson & Draper, 2003). Although healthcare professionals may be proficient in one or more languages, they often experience problems with applying communication skills in medical practice (Kurtz *et al*, 2003). With appropriate teaching effective communication skills, including language, can be acquired and retained (Aspergren, 1999; Kurtz, Laidlaw, Makoul & Schnabl, 1999; Makoul & Schofield, 1999; Spencer & Silverman, 2001).

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The CanMEDS framework is useful for providing a framework for developing effective communication between health care worker and patient, and to place communication process skills within a comprehensive clinical context. The framework is designed to provide structure in the consultation process, as well as to build a relationship with the patient. In order to give structure to the consultation process, there must be a flow of communication between patient/client and healthcare professional. To enable that, there must be a sequence of tasks to be performed. A relationship can be built between patient/client and healthcare professional by using appropriate communication skills and involving the patient/client. The patient/client can only be involved if the healthcare professional is able to communicate in the language of the patient/client and when appropriate language skills are applied (Spencer & Silverman, 2001). To be able to communicate in the language of the patients/clients, students must participate in an effective language acquisition course.

2.4.2 Structure in which language courses at FMHS occur

At FMHS, different disciplines receive different isiXhosa language courses. IsiXhosa is taught in the interprofessional phase in year one of MBChB by the African Languages Department at Stellenbosch University. A large number of students (±300) is accommodated simultaneously. After the first year, MBChB students do not receive further training in isiXhosa and therefore they did not form part of this study.

In the first year of Speech-Language and Hearing Therapy, students also receive isiXhosa from the African Languages Department at Stellenbosch University. Students receive this programme together with students studying for different professions. Therefore, it is a general isiXhosa course which is not specific to the needs of Speech-Language and Hearing Therapy students in the healthcare context. However, in the second, third and fourth year of Speech-Language and Hearing Therapy, students receive an isiXhosa communication course which is specific to their needs. For this course students are divided into groups of a maximum of 20 students (this course is further described in Chapter 3).

In the same way, second and third year Human Nutrition, as well as second and third year Occupational Therapy students receive an isiXhosa communication course which is specific to the

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needs of these respective undergraduate programmes (further described in Chapter 3). These students do not receive any isiXhosa training in their first and fourth year of studies.

With regards to Physiotherapy, first year students receive isiXhosa from the Language Centre at Stellenbosch University. This isiXhosa component forms part of a module called Personal and Professional Development (PPD) which is presented in the first semester. In the second semester of the first year, as well as the first semester of the second year, Physiotherapy students also receive the isiXhosa communication course which is specific to the needs of Physiotherapy (further described in Chapter 3).

From the above mentioned it is thus clear that different disciplines receive different language courses at different times during their studies. It is also clear that all disciplines do not receive a language course for the full duration of their studies. Speech-Language and Hearing Therapy is the only discipline receiving language training for all four years of studies, even though these are two different language courses.

The following table summarises the abovementioned explanation regarding the language courses in the respective undergraduate programmes in the FMHS.

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Table 2-1: Language courses in respective undergraduate programmes

Discipline	First year	Second year	Third year	Fourth year
MBChB	General language course			
Speech Therapy	General language course	Clinical communication course	Clinical communication course	Clinical communication course
Occupational Therapy		Clinical communication course	Clinical communication course	
Human Nutrition		Clinical communication course	Clinical communication course	
Physiotherapy	1st semester: General medical language course 2nd semester: Clinical communication course	Clinical communication course (1st semester)		

2.5 Conclusion

This chapter has outlined health sciences education and training in an international context, a South African context, and also in the context of Stellenbosch University Faculty of Medicine and Health Sciences. It focused specifically on the epistemology and pedagogy of health professions education, and the CanMEDS framework internationally. It also provided a discussion regarding reforms in health sciences education in South Africa, as well as the key elements that inform health sciences education and training in South Africa. Furthermore, the profile of the 'Stellenbosch healthcare worker' was described. Finally, the structure within which language courses at FMHS occur was explained.

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In the next chapter, I will discuss the importance of communication as a critical skill of the health professions graduate. Challenges regarding communication in the health care context will be explored with possible solutions in terms of effective language courses to address these communication challenges.

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3 COMMUNICATION AS CRITICAL SKILL OF THE HEALTH PROFESSIONAL

3.1 Introduction

The aim of this chapter is to argue the importance of communication as a critical skill of the health professional. The aim is also to explain the effect of communication on patient-centredness. Furthermore, this chapter aims to explore challenges regarding communication in the health care context and propose possible solutions in the form of language courses to address these communication challenges.

Firstly, this chapter starts with defining 'communicator' as a graduate attribute, and providing an outline of the respective competencies of the 'communicator' attribute. Secondly, the effect of communication on patient-centredness will be discussed. This will be followed by a discussion regarding a language course as strategy to address communication barriers and challenges (also refer to Chapter 5, section 5.2). Finally, an outline of the language in communication course presented at Stellenbosch University, Faculty of Medicine and Health Sciences will be presented.

3.2 Communication as critical skill

The communicator role in the CanMEDS framework was initially designed to present the ideal of physicians, as communicators, to effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter. As discussed in Chapter 2 (section 2.4), this framework with its key and enabling competencies was adapted and refined to meet the needs of the respective allied health professions programmes at FMHS. After refining the key and enabling competencies, the communicator role can be defined as "healthcare professionals who effectively facilitate the carer-patient/carer-client relationship and the dynamic exchanges that occur before, during and after interventions" (Faculty of Medicine and Health Sciences, Stellenbosch University, 2013: 5). The key competencies of the communicator are as follows (Faculty of Medicine and Health Sciences, Stellenbosch University, 2013: 5):

- Develop rapport, trust and ethical therapeutic relationships with patients/clients, families and communities from different cultural backgrounds.

  Demonstrate a patient/client-centred and community-centred approach in interactions with patients/clients and their families.

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Practise good communication as a core clinical skill, recognising that effective communication between the healthcare professional and the patient/client can foster patient/client and professional satisfaction, as well as adherence and improved clinical outcomes.

Establish positive therapeutic relationships with patients/clients and their families characterised by understanding, trust, respect, honesty, integrity and empathy.

Respect patient/client confidentiality, privacy and autonomy.

Motivate patients/clients and their families and communities to take personal responsibility for their health.

Demonstrate flexibility in the application of communication skills.

- Accurately elicit and synthesise relevant information and perspectives of patients/clients and families, communities, colleagues and other professionals.

  Gather information about health conditions and functioning, as well as about a patient/client's beliefs, concerns, expectations and illness experience.

  Seek and synthesise appropriate information from relevant sources, such as a patient/client's family, community, caregivers and other professionals.

  Communicate effectively by listening, clarifying uncertainties, probing sensitively, and being aware of, and responsive to, non-verbal cues.

- Convey relevant information and explanations accurately and effectively to patients/clients, families, communities, colleagues and other professionals as well as statutory and professional bodies.

  Deliver information to a patient/client and family, communities, colleagues and other professionals in a humane manner and in such a way that it is understandable, and encourages discussion and participation in decision-making.

  Present well-documented assessments and recommendations effectively in written and/or verbal form in response to a request from another healthcare professional.

  Compile accurate reports as needed and required for statutory and professional purposes.

- Develop a common understanding of issues, problems and plans with patients/clients, families, communities, colleagues and other professionals, to develop a shared plan of care/action.

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Identify and explore problems to be addressed effectively from a patient/client encounter, including the patient/client's functioning, context, responses, concerns and preferences.

Respect diversity and difference and the influence of ethnicity, gender, religion, education and culture on decision-making.

Encourage discussion, questions and interaction.

Engage patients/clients, families, communities and relevant healthcare professionals in shared decision-making to develop a plan of care/action.

Effectively address challenging communication issues, such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding.

Communicate effectively with patients/clients and their families about costs and risks implicit in clinical interventions and care, in order to minimise potential medico-legal issues.

- Convey effective and accurate oral and written information about a clinical encounter.

  Maintain clear, accurate and appropriate records (written or electronic) of all clinical encounters and plans.

  Present effective oral and written reports of clinical encounters and plans, using language, visual, information technology and numeracy skills.

  Recognise ethical and legal issues in compiling patient/client documentation.

Language is essential to the role of the communicator as described by the key competencies. In order to achieve the outcomes as described by FMHS (2013) synchronicity between the language use of the healthcare professional and the patient in this specific context is required. Where healthcare professionals are not able to consult patients/clients in their (the patients'/clients') language, difficulties are experienced with understanding patients, making themselves understood, and asking questions (Levin, 2004; 2006; Schlemmer & Mash, 2006), and language barriers occur (Levin, 2011).

However, communication is much more than merely disposing of vocabulary and correctly applying language structures. It is about understanding cultural differences, and building relationships and trust by using appropriate communication skills. It is also about understanding a

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person as a whole, and thus focusing on the importance of patient-centeredness, and, in turn, patient-centred communication. Epstein (2005) describes this well when he refers to patient-centred communication as having the ability to help patients/clients understand, and involving them in choices by communicating effectively.

Patient-centred communication must be enabled through shared decision making and effective dynamic interactions with patients, families, caregivers, other professionals, and other important individuals. It is essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care. Poor communication can lead to undesired outcomes, and effective communication is critical for optimal patient/client outcomes (Frank, 2005).

3.3 Patient-centredness and communication

Providing patient-centred care is an important aspect of health care. Patient-centred care "puts patients at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families, and health care services providers" (British Columbia Ministry of Health, 2015: 1). Numerous key competencies are incorporated in patient-centred care, including self-management, shared and informed decision-making, an enhanced experience of health care, improved information and understanding, and the advancement of prevention and health promotion activities. Apart from these key competencies, a further four core principles are identified to provide a foundation for patient-centeredness, namely dignity and respect, information sharing, participation and collaboration (British Columbia Ministry of Health, 2015). To gain respect, it is essential to develop rapport with patients. Successful communication is also dependent on developing rapport. A strong rapport can be built through warm greetings, eye-contact, a brief non-medical interaction, or requiring about an important life event (Bakic-Maric & Bakic, 2008). Healthcare professionals should start consultations by making eye contact with the patient/client, shaking the patient's/client's hand, introducing him/herself by using his/her first name and surname, and introducing his/her role as healthcare professional. Healthcare professionals should also strive towards making patients/clients feel at ease by initially enquiring about non-medical areas of the patient's life. Once patients/clients feel at ease, healthcare professionals can continue by asking

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the patient to explain the reason for having to see a healthcare professional (Bakic-Maric & Bakic, 2008).

Furthermore, active listening is required for gaining respect. Active listening is applied when the values, beliefs and cultural norms of patients/clients and families are incorporated into health care delivery. This must be accompanied by sharing accurate and complete information with patients/clients and families on what decisions are to be made. During this process of active listening and information sharing, patients and families should be encouraged to actively participate in the consultation process. In turn, patients/clients and families should be provided with sufficient opportunities to engage with healthcare professionals in a collaborative manner for quality improvement of delivery of care.

During the process of active listening, empathy should be shown by healthcare professionals. Empathy is considered a vital aspect of healthcare professionals due to the fact that it enhances patient satisfaction, enablement, as well as improvement in health outcomes (Jani, Blane & Mercer, 2012; Derksen, Bensing & Lagro-Janssen, 2013). In the clinical context, empathy can be defined as the ability to "understand the patient's situation, perspective, and feelings, communicate that understanding, and to act on that understanding with the patient in a helpful (therapeutic) way" (Lundy, Bikker, Higgins, Watt, Little, Humphries & Mercer, 2015: 2; Mercer & Reynolds, 2002). Empathy and the concept of patient-centred care is thus closely related (Mercer & Reynolds, 2002).

There are many different views of patient-centredness and associated communication skills; however, a patient-centred healthcare professional would have the ability to effectively engage patients/clients during the consultation through the process of actively listening (Boyle, Dwinnell & Platt, 2005). It is the responsibility of the healthcare professional to invite the patient/client to motivate his/her reason(s) for seeking health care, indicating that the healthcare professional is interested. After inviting the patient to do this, the healthcare professional should carefully listen to the patient/client without interrupting him/her. During the listening process, the healthcare professional should focus on aspects such as the ideas, concerns and expectations of the patient/client. This will enable the healthcare professional to respond effectively to the patient/client. Furthermore, it is ideal for the healthcare professional to be able to summarise what the patient/client has said, using his/her own words. By applying these communication skills, the healthcare professional demonstrates his/her understanding of the patient's/client's concern and,

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in turn, that he/she believes the patient/client. This leaves the patient/client feeling valued and respected (Hedberg & Lynoe, 2013).

Patient-centred care is recognised as one of the key aspects within the health care system, and should be employed, irrespective of patients'/clients' nationalities and cultural differences (Institute of Medicine, 2001). It is evident that patient-centred care leads to improved patient/client satisfaction and thus quality of care (Epstein, Mauksch, Carroll & Jaén, 2008; Bertakis & Azari, 2011; Bertakis & Rahman, 2011). Furthermore, it is evident that patient-centred care can also result in greater work satisfaction for healthcare professionals (Irwin & Richardson, 2006). However, effective communication is essential in order to enhance patient-centredness.

3.4 Challenges with regards to communication

Effective communication is an essential skill for healthcare professionals in order to accurately obtain the necessary information from their patients/clients. Training in communication skills is therefore an important component of health professions programmes. However, communication skills training is often done in isolation, and not as part of the context in which it needs to be applied (Silverman, 2009).

Besides communication skills training being offered as a separate entity, it largely remains in the early campus-based years of medical courses. As a result, novice students, who are still unable to effectively communicate with patients in a clinical context, are being presented with advanced skills (Hook & Pfeiffer, 2007).

There is thus a strong argument for providing a clinical learning environment which is suitable for communication skills training. Not only is it necessary to create a clinical learning environment, but also, more specifically, focussing on discipline-specific communication skills training (Conn *et al*, 2012). Not having effective communication skills training results in healthcare professionals experiencing various communication barriers in their practice. Having to use interpreters is one of these barriers.

The use of interpreters may influence the success of communication, and consequently health care (Penn, 2007). Sometimes nurses or cleaners are used as interpreters between healthcare professionals and patients/clients. This interferes with efficient practice, because the healthcare professional first needs to consult an interpreter. Healthcare professionals cannot proceed with

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confidence because they are unsure of the accuracy of the interpreting process. Furthermore, the confidentiality of information concerning a patient can be compromised once interpreters are used. This practice may cause negative attitudes when patients/clients are not understood. In addition, interpreters are not necessarily acquainted with medical terms used by healthcare professionals (Schlemmer & Mash, 2006; Kilian, Swartz & Joska, 2010). Therefore, incorrect diagnoses can be made, or wrong directions for the use of medications can be given (Schlemmer & Mash, 2006). The use of nurses or other *ad hoc* interpreters further decrease the quality of patient care, including inappropriate discharge which leads to patient distress, medical consequences and non-compliance with medication, as well as anger from healthcare professionals and resentment from nurses (Saohatse, 1998). Furthermore, patient satisfaction deteriorates. Cross-cultural misunderstandings are also likely to occur in this situation. It is therefore essential to have culturally competent healthcare professionals in the health care system.

In a study done by Levin (2006) language difficulties as a barrier to health care were investigated. The study was done at the Red Cross Memorial Children's Hospital (RCH) which is a paediatric teaching hospital in Cape Town. In this particular setting the majority of health care workers are English speaking, while the minority are either Afrikaans or isiXhosa speaking. Approximately half of the patients seen on a daily basis spoke isiXhosa, whereas the rest were Afrikaans or English speaking. At the time of the study, there were only two interpreters and their services were only available during office hours. This created communication problems due to the fact that the consultation could not take place in the patient's language. There was thus a failure on the patient's side to understand the English spoken by the healthcare professional which created a further difficulty, i.e. understanding the medical terminology. The study found that difficulties experienced with language had three potential negative effects: 1) language difficulties are a significant barrier to good quality of health care; 2) poor communication has a tremendous effect on patients; and 3) the use of medical terminology is a great barrier to patients' understanding of healthcare professionals (Levin, 2006).

Health problems that are associated with socio-economic disadvantages can be reduced by creating and maintaining a health care system with culturally competent healthcare professionals. Cultural competence is an important aspect of quality health care which contributes towards overcoming communication barriers. By providing culturally competent health care, health outcomes can be

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improved and, in turn, the efficiency of clinical and support staff will be increased, resulting in greater patient satisfaction (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003).

According to Stevenson and Davis (1994) cultural and linguistic competence refer to the behaviours, attitudes, and policies that enable effective work in cross-cultural situations. More specifically, culture refers to patterns of human behaviour that include factors such as language, thoughts, communications, actions, customs, beliefs and values. On the other hand, competence refers to the ability to function effectively, either as an individual or an organisation, within the context of cultural beliefs, behaviours and needs of the community (Sarver & Baker, 2000). Ideally, in order to have a culturally competent health care setting, the following aspects should be developed: 1) culturally diverse staff reflecting the diverse communities served; 2) healthcare professionals who are able to speak the language of the patients/clients; 3) training for healthcare professionals regarding the culture and language of the patients/clients they serve; 4) culturally specific health care systems (Anderson *et al*, 2003).

The challenges in creating a culturally competent health care setting were highlighted during an informal discussion with a staff member in one of the clinical divisions at Tygerberg Hospital. The need for isiXhosa speaking healthcare professionals in this particular division where there are four shifts per day, and only three isiXhosa speaking nurses, was evident. Between 15 and 20 patients are daily seen of whom half are isiXhosa speaking. Problems are experienced during consultations when English or Afrikaans speaking / non-Xhosa speaking doctors are often unable to communicate with isiXhosa speaking patients. This is further exacerbated because the directions for the use of medication are only available in English or Afrikaans. When available, an isiXhosa speaking nurse, who is not always familiar with all the medical terms, is used as an interpreter. This reflects the daily challenges faced by health practitioners and patients. It is thus clear that healthcare professionals need to be able to communicate in the language of their patients and that effective language courses are needed that will equip healthcare professionals with the necessary communication skills.

3.5 Language learning to address communication challenges

Pfaff and Couper (2009) advance the view that second language learning has moved away from the traditional focus on grammar and translation to communicative and task-based methods. The

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natural approach of Krashen (1983) complements the view of Pfaff and Couper and suggests that language is acquired by hearing the language, and not by learning its formal grammatical rules. Grammatical rules can be used to correct language use when language has already been acquired through listening. Second language learning in the health care context is even more challenging as healthcare professionals are not necessarily interested in or motivated to acquire a second or third language. Even for those healthcare professionals who would like to be able to speak the language of their patients, there is little expertise on effective ways of successfully acquiring a second language in the health care context (Schlemmer & Mash, 2006).

One of the few studies in this regard was done by Pfaff and Couper (2009) to establish ways in which healthcare professionals acquire the language of their patients. Healthcare professionals were of the opinion that it is useful to immerse themselves in the community where the target language is spoken, or to have a tutor. The skill of listening in learning a language is very important. By listening, vocabulary and understanding of implied meaning are expanded, and so, effectively learning a language depends, amongst other things, on how much one listens and integrates what has been learnt. It is one thing to learn a new language, but it is another to actually apply what has been learnt in practice. The ideal is to be prepared to practice speaking with patients confidently. Not only will the healthcare professional develop to be communicatively competent, but he/she will also build deeper connections. Speaking the language will establish a deep relationship with patients, it will remove barriers between health care worker and patient, and it will enable communication on a level that wouldn't have been possible with an interpreter involved. Furthermore, confidentiality improves, and patients feel more satisfied with speaking their own language (Pfaff & Couper, 2009).

Pfaff and Couper's (2009) study further confirmed that learning a new language means also learning a new culture. This includes respect for one another and how people deal with one another. Naturally, the emotional bonding with the culture adds a further dimension to language learning.

To learn a language, one needs to be motivated. Motivation can occur on different levels such as being inspired by those who can speak the target language well, frustration in having to work with interpreters, or learning out of pure necessity as interpreters are either not available or do not want to help (Pfaff & Couper, 2009).

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Furthermore, formal language classes tend to not always be successful as they produce healthcare professionals who are competent in grammar, but unable to communicate with patients. The availability of books can help learners with grammar, but not with acquiring the necessary vocabulary in order to have a coherent conversation (Pfaff & Couper, 2009).

Second language learners often experience difficulties in terms of communication due to their limited language knowledge. This can be remedied by improving the skill of strategic competence. Strategic competence can be defined as "verbal and non-verbal communication strategies that may be called into action to compensate for breakdowns in communication due to insufficient competence" (Meenakshi, 2015: 71). Having strategic competence will enhance the communication process by assisting in getting meaning across successfully (Meenakshi, 2015).

The above mentioned language learning approaches can be represented diagrammatically as follows in the language learning cycle:

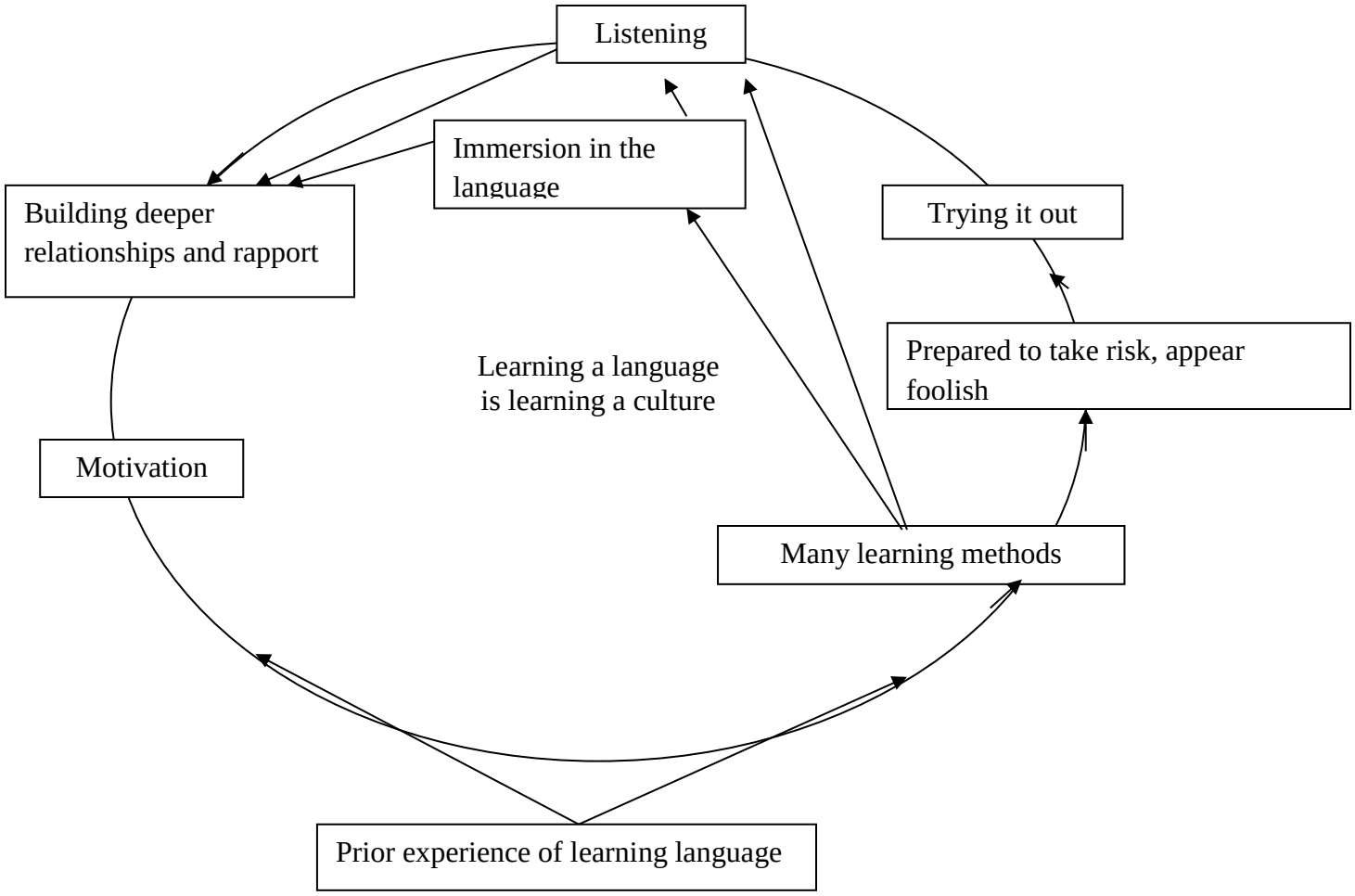

Figure 3-1: The language learning cycle (Pfaff & Couper, 2009)

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From the diagram it is clear that several approaches to language learning can be used but that a strong emphasis on a communicative approach is required. Even though some forms of grammar learning tend to be used, formal grammar learning is not necessary. However, there is an assumption that a pure communicative approach to language learning produces speakers who make many errors which could have been corrected with the knowledge of grammar (Hammerly, 1991). The question is: what are the needs of the healthcare professional - speaking the language flawlessly or communicating intelligibly? Language learning is seen as a noble goal, but it is a goal which is not easy to achieve in a busy working practice of health care (Pfaff & Couper, 2009). In this context the idea is not to be fully bilingual, but rather to create a sufficient basic understanding of the language of patients, as well as respect for their culture (Schlemmer & Mash, 2006).

However, to learn a language, it is necessary to be prepared to practice speaking the language and, in turn, a better understanding of the language will be created. For this reason, the attribute of self-efficacy plays an important role. Self-efficacy can be defined as the belief in one's capability to arrange courses which will contribute towards reaching different types of performances (Artino, 2012). Self-efficacy is often also described as 'task-specific self-confidence' and is regarded as a key aspect of achievement, motivation and learning in a variety of contexts (Artino, 2012). It is important to realise that self-efficacy is the belief of one's capability and does therefore not necessarily reflect one's actual capability. Sometimes it is possible that individuals overestimate their capabilities. The opposite is also possible; one's capabilities can be underestimated (Pajares, 1996; Artino, 2012).

To have sufficient knowledge and skills is not enough; it is also necessary to have the belief that a particular task can be performed under challenging circumstances (Artino, 2012; Bandura, 1997). In this context, it is the belief that successful communication with patients can occur under challenging conditions. Therefore, effective functioning requires both skills and efficacy beliefs. Skills and efficacy beliefs are two components which develop as individuals progress and learn (Artino, 2012).

Self-efficacy tends to affect the choice of activities, effort and persistence. If the self-efficacy for performing and accomplishing a particular task is low, the task may be avoided. However, if the

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self-efficacy is high, it is most likely that a particular task will be performed. Individuals who are sure of their capabilities will also persist longer in difficult situations (Artino, 2012).

3.6 Theoretical perspectives on language learning within the context of the isiXhosa language course

During the last decade, South Africa has experienced many changes in the field of education. New education policies and curricula were introduced. However, a lot of criticism was directed at the insufficient consideration of long-term consequences and effects before implementation of these policies and curricula. It is thus important to revisit teaching and learning trends in order to ensure that the basic principles of curriculum planning and design are integrated into future plans and strategies (McDonald & Van der Horst, 2007).

Curriculum can be defined in various ways; it is evident that a single definition of curriculum does not exist (Posner, 2004). After careful examination of the intended learning objectives, plan of study, content outline, and the series of steps that students should be able to complete, Posner (2004) defines the curriculum as a series of courses students should go through, i.e. a matrix of courses during the course of a student's education. However, in order to design an appropriate curriculum for health care professionals, it would be beneficial to review the definition by the Postgraduate Medical Education and Training Board (PMETB) (Grant, 2006):

> Curriculum is a statement of the intended aims and objectives, content, experiences, outcomes and processes of an educational programme which includes the following:
>
> - a description of the training structure
> - a description of the expected methods of learning, teaching, feedback and supervision
>
> The curriculum should cover specialty-specific areas and the syllabic content should be stated in terms of what knowledge, skills, attitudes and expertise the learner will achieve.

For the purpose of this research project, the term 'curriculum' can also be applied to a language course presented to Human Nutrition (HN), Occupational Therapy (OT), and Speech-Language and Hearing Therapy (SPH) students. The curriculum thus not only entails specific content

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presented to these students; it also specifies the objectives and outcomes that form an integral part of the curriculum, as well as particular assessment procedures.

Different learning programmes can be developed to serve the different communicative needs of diverse groups of learners (Nunan, 2003). Breen (1984) states that the objectives (communicating in the target language) of a curriculum and the means (classroom procedures that develop communication in the target language) start to emerge when communication is placed at the centre of the language curriculum. Therefore, the curriculum implemented for HN, OT, and SPH students was designed to follow a communicative approach. Students thus have the opportunity to partake in activities such as group dialogues or engaging in text-to-speech activities on the e-learning platform (as described in section 3.6.1). Also, when students are being assessed, they are required to do an oral with a simulated patient, instead of a written test. Students are therefore continuously forced to speak the language, rather than focusing on writing skills.

As communication is placed at the centre of this language course, the framework provides for: 1) creating a natural or real life environment, 2) teaching language for specific purposes, 3) the CanMEDS framework, 4) the SPICES model (described in Chapter 2), and 5) constructive alignment.

3.6.1 Teaching and learning in simulated environments

When teaching or assessing students, the setting is created in such a way to reflect a natural or real life situation. Simulation is used, because it is not possible to do all training in real life contexts, nor to ensure that all important learning opportunities will be available in the clinical environment (Kalaniti & Campbell, 2015) simulation is used. In the simulated environment, the content is based on various scenarios similar to those encountered in the clinical environment. During class interactions, students have the opportunity to enact these scenarios in groups. When having orals, simulated patients are used in order to expose students to different kinds of situations, and different kinds of personalities they might deal with, and, in turn, allowing students to practice what they have learnt in class, including their communication skills.

Simulated patients are used, because ‘real patients’ might not always be available for clinical teaching purposes, and they might not always be willing to have repeated exposure in terms of

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investigation and treatment procedures to students (Harden, 2012). A simulated patient is any individual trained to accurately portray the symptoms of a patient, given the particular context (Howard & Barrows, 1993).

Simulated patients are ideal for the training and assessment of, for example, history taking, physical examinations, and even communication skills. There has been a growing recognition of the advantages of simulated patients, and they have thus been integrated into numerous medical curricula (Reznick, Blackmore, Dauphinee, Rothman & Smee, 1996; Sutnick *et al*, 1993). For this reason, the use of a simulated environment and simulated patients was included in the isiXhosa language framework.

Willis (2004) argues that beginner additional language learners learn more easily in a natural or real life environment. It is necessary that learners take note of useful words and start putting together words and phrases in order to convey a message. According to Ellis (2003, cited in Willis, 2004) it is more practical if syllabi are designed to begin with communicative task-based modules that focus on the acquisition of vocabulary in meaningful contexts. For health care workers this would presuppose contextualized vocabulary learning and communicative tasks where the focus is on patient care.

3.6.2 Teaching for specific purposes

In order to focus on the acquisition of vocabulary in meaningful contexts, the curriculum implemented for HN, OT, and SPH students, respectively, was designed specifically to fulfill their communicative needs and to have a very definite focus. The focus is on the needs of HN, OT, and SPH learners, their specific context and the language use in this particular context. It is thus a curriculum for specific purposes. Hyland (2009) argues that teaching language for specific purposes is necessary to satisfy the demands of specific employer groups in order to facilitate 'work-readiness' in the employee. He further argues that the focus and attention should be on addressing these specific needs in order for learners to apply these language skills in the contexts in which they will be working. A specific purpose curriculum based on a needs analysis for the context should include specific language features, language skills and communication/ interaction skills which are needed in a specific environment.

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Teaching for specific purposes is advantageous in the sense that it is time and energy efficient. Learners are able to learn relevant language skills and address specific language needs in order to communicate in specific contexts. Furthermore, learners can adapt to specific registers and language demands of a community when learning languages for specific purposes (Basturkmen, 2006; Hyland, 2009). Learning a language for specific purposes can therefore also enhance the level of professionalism expected in a specific context.

3.6.3 SPICES model

Considering the discussion of the SPICES model in Chapter 2, the language framework for the HN, OT, and SPH students incorporates aspects of the SPICES model. The SPICES model is a key tool for organising curricula in medical education. The key elements of this model are student-centred learning, problem-based learning, integrated or inter-professional teaching, community-based education, elective studies, and a systematic or planned approach. Incorporating these various aspects into the framework allows for a more student-centered and community-oriented approach. Furthermore, learning in a clinical context can be structured as such to meet the needs of students and the curriculum requirements (Dent, 2014).

The framework for HN, OT, and SPH students specifically includes the aspects of being student-centered, integrated or inter-professional, and systematic. Student-centeredness is ensured by availing manuals to students which are related to the clinical problems encountered with patients in hospitals. According to Dent, Angel-Preece, Ball & Ker (2001), students benefit extensively from the 'unhurried' environment and the time to practice their clinical and communication skills.

The clinical problems experienced in hospitals and the communication skills needed to deal with these problems must be integrated. In order to do this, students are taught relevant terminology which is reinforced by activities on the e-technology platform and then used in context with trained patients. The classroom setting aims at representing a natural context, and thus students are able to relate to it, because what they daily deal with during their clinical rotations, is presented in the manuals. Dent *et al* (2001) advance the view that students can be stimulated to integrate their learning by reflecting on their existing knowledge experienced elsewhere.

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Focusing on the specific clinical encounters in the HN, OT, and SPH context also allows for a systematic approach to clinical communication teaching. It is thus ensured that the clinical communication teaching session matches the clinical problems encountered. To ensure that they are system-specific with relevant content for the purpose of teaching communication skills, the language practitioners involved experienced the clinical rotations themselves. In this way, the alignment between clinical situations and relevant communication skills is ensured.

3.6.4 Constructive alignment

As discussed in Chapter 2, it is common for education to be described in terms of the expected outcomes of teaching and learning. The language curriculum implemented for the HN, OT, and SPH students, respectively, is built on a number of outcomes that the students should be able to do on completion of the course. Not only do outcomes inform what or how well students should be able to do something, they also inform the teacher about the level of learning required, particular approaches to take when designing activities, and the way in which assessments should be designed to measure the extent to which the prescribed outcomes have been reached (Barrow *et al*, 2010). There should thus be a constructive alignment between assessment and the activities designed.

Biggs (1996) argues that the emphasis of constructive alignment is on developing activities aimed at starting the process of achieving learning outcomes. Bearing this in mind, it is important that the assessment is aimed at the performance of the required outcomes (Biggs & Tang, 2007).

One can thus argue that constructive alignment is based on theories of learning, i.e. the understanding that knowledge is constructed by learners using their own activities. It is not a process of instruction by the teacher. Students need to synthesise what they learn and do in order to link new information to existing knowledge and experiences (Barrow *et al*, 2010). For example, looking at the framework for HN, OT, and SPH students, synthesis will be demonstrated by the ability to link communication skills to their existing experiences of consultations with patients in a clinical context. This will help students to make personal sense of new information acquired.

Therefore, it is important to be aware of the need to define learning outcomes, understand how learners learn, and ensure that teaching and learning methods are aligned to facilitate learning. It

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is also necessary to understand how the overall programme is structured within the work environments (Barrow *et al*, 2010).

To summarise, the course framework serves as a guide to ensure that learners are given sufficient opportunities to acquire the knowledge, skills and attitudes necessary for communication with patients in the clinical context. As argued by Samarasekera, Karunathilake and Dias (2006), learning outcomes need to be clearly formulated enabling students to monitor their own progress. Students need to be autonomous in the learning process; the idea is that students achieve what is expected instead of trying to 'catch them out' in assessments. Collaboration and interaction with peers, teachers, and simulated patients are important to help deepen understanding. New situations brought to class by students should be acknowledged by developing further activities allowing students to integrate existing knowledge with these new concepts (Barrow *et al*, 2010).

3.7 Conclusion

This chapter has outlined the importance of communication as a critical skill of the health professions graduate. It is clear that communication is an essential aspect of our daily lives. More specifically, it is essential to effectively communicate in the language of patients in order to enhance quality of care.

Due to the need to implement relevant language curricula in medical schools in order to equip health care workers with the necessary communication skills, Stellenbosch University Faculty of Medicine and Health Sciences has developed and implemented isiXhosa communication courses in the undergraduate degree programmes. In this particular communication course, the setting is created to reflect a real life situation, i.e. clinical encounters with patients in hospitals are used as foundation to teach language in communication. It is also based on teaching language for specific purposes. With teaching for specific purposes, the focus is on specific content, knowledge and skills needed for the contexts in which students will be working.

Communication with patients in the health care context entails more than just the language. It is also about being professional in their approach, building relationships and trust, and focusing on the importance of patient-centered communication. For this reason, the communication course also includes the role of the communicator as part of the CanMEDS framework. Focusing on the

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communicator competency enables teaching and learning by accurately conveying relevant information, developing understanding of certain issues and problems experienced by patients, being sensitive in word choice, respecting cultural differences, and demonstrating flexibility in the application of communication skills.

To ensure effective clinical communication skills, alignment between clinical encounters and relevant communication skills must be ensured. Therefore, the communication course guarantees that learners are given sufficient opportunities to acquire the knowledge, skills and attitudes necessary for communication with patients in the clinical context.

In the following chapter, the methodology used to evaluate the isiXhosa clinical communication course will be described.

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4 RESEARCH METHODOLOGY

4.1 Introduction

The aim of this study was to determine the extent to which the isiXhosa clinical communication course for students in Allied Health Professions at Stellenbosch University Faculty of Medicine and Health Sciences satisfies the communicator competency requirements of the modified CanMEDS framework. This chapter describes how research to achieve this aim was conducted.

The chapter starts with reiterating the research questions of this study. This is followed by a discussion of the research paradigm and research design. Thereafter, an outline of the study participants and the study population is given. Following this, the methods used for collecting the data and for analyzing the data are described. Lastly, ethical considerations, as well as the limitations of the research study are dealt with.

4.2 Research questions

The main research question for the study was:

To what extent does the isiXhosa clinical communication courses of the Faculty of Medicine and Health Sciences at Stellenbosch University in Speech-Language and Hearing Therapy, Human Nutrition, and Occupational Therapy satisfy the communicator competency requirements of the modified CanMEDS framework?

In order to answer this research question, the following sub-questions were investigated:

1. To what extent does the course documentation of the current isiXhosa communication course provide evidence of meeting the requirements of the modified CanMEDS communicator competency?

2. What are Allied Health Professions students' perceptions of the extent to which the isiXhosa clinical communication course equips them to meet the requirements of the CanMEDS communicator competency?

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3. To what extent are lecturers of the isiXhosa clinical communication course attempting to meet the requirements of the modified CanMEDS communicator competency?

4. To what extent do observations of clinical consultations of Allied Health Professions students in the course provide evidence of meeting the requirements of the modified CanMEDS communicator competency?

4.3 Research paradigm

Paradigms play an important role in research and can be defined as "a system of ideas or theoretical principles that determine, maintain and reinforce our way of thinking about an issue or a topic. It is a set of basic beliefs that are accepted on faith with no way of establishing their ultimate truthfulness" (Guba & Lincoln, 1998: 200).

Traditionally, the paradigms underpinning research can be distinguished as scientific, naturalistic paradigms on the one hand, and constructivist paradigms on the other hand. A scientific, naturalistic paradigm holds that the world is not dependent on our perception or understanding of that particular world. It is thus referred to as mind-independent, i.e. reality is regarded as objective within which facts are experienced as universal (Plowright, 2011). In contrast with a scientific, naturalistic paradigm, a constructivist paradigm posits there is not only a single objective reality and that reality is indeed mind-dependent, i.e. reality is constructed through means of relationships, activities and shared understandings (Plowright, 2011; Creswell & Plano Clark, 2007). A constructivist paradigm is thus interested in social reality, i.e. it is "generated by the way we think or talk about it, by our consensus about its nature, by the way we explain it to each other and by the concepts we use to grasp it" (Collin, 1997: 2-3).

For the purpose of this study, the research was guided by a more recently developed approach which is most commonly associated with mixed methods research, namely a pragmatic paradigm (Teddlie & Tashakkori, 2009). This approach was chosen as it is practical and relevant to all types of research (Denscombe, 2008). Due to the fact that it remains questionable whether it is ever possible to attain an undeniable knowledge of reality, irrespective of the perspective taken or what the understanding is, pragmatists argue that truth is seen as that which works, and therefore focuses

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on a specific problem to be researched, as well as the consequences of the research (Plowright, 2011; Creswell & Plano Clark, 2007; Miller, 2006). The results obtained from this study show that the isiXhosa clinical communication course can be considered as a 'work in progress' and is therefore subject to change, amendment and revision (Plowright, 2011).

4.4 Research design

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

Posavac and Carey (1992) distinguish between four types of evaluation, namely the evaluation of need, the evaluation of process, the evaluation of outcome, and the evaluation of efficiency. The evaluation of need aims to establish what the particular needs of the target population are with regards to the type of programme being considered. According to Posavac and Carey (1992) it is important to assess the need as a precondition for effective programme planning, and thus also programme evaluation.

Upon completion of the design and development of a programme, it is implemented within a particular setting. Once implemented, it is necessary to determine whether the programme has been implemented as initially designed, whether the programme serves the target population, and whether services are delivered as originally planned (Posavac & Carey, 1992).

When it has been determined that a programme has been implemented as initially planned, the focus is on the intended and unintended outcomes of the programme. These outcomes could possibly include: 1) behavioural changes (more skilful trainers, literate learners, and

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knowledgeable students); 2) attitudinal changes (more positive attitudes towards, for example, other cultures); and 3) better services (Posavac & Carey, 1992).

Finally, after evaluation of the need, the process, and the outcome, the focus is on the costs involved, i.e. evaluation of efficiency. Evaluation of efficiency entails determining whether funds were correctly spent for the intended purpose, and whether the programme is administered at the same cost as other similar programmes (Posavac & Carey, 1992).

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

For the purpose of this study, the focus will be on the evaluation of need, the evaluation of process and the evaluation of outcome. Evaluation of efficiency will not be focused on, as the costs involved will not be measured. The aim is merely to determine the effectiveness of the isiXhosa clinical communication course in terms of preparing students for communication in the clinical context.

4.5 Sampling of participants

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

Three groups of students were included, namely Occupational Therapy (third year) (OT) students, Human Nutrition (third year) (HN) students, and Speech-Language and Hearing Therapy (SPH) (fourth year) students. Speech-Language and Hearing Therapy students are divided into three groups who rotate for class during the year. Due to practical reasons only one of these groups could be used for the study. All of these students were selected to participate in this study as they were in their final study year of receiving the isiXhosa clinical communication course. Being in their final year, these students were best to judge the effectiveness of the communication course, as well as the extent to which they have been prepared to communicate in the healthcare context. Fourth year HN and OT students could possibly have been used as well, as they already work with ‘real’

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patients. However, it would have entailed ethical and logistical challenges (see Chapter 1, section 1.8).

Lecturers who were involved in teaching the isiXhosa clinical communication course were selected to participate in the study. There are only two isiXhosa lecturers, and therefore both of them were interviewed. One lecturer has been teaching the isiXhosa course for five years, while the other lecturer has been teaching the course for almost four years.

In order to facilitate maximum representation, all students (HN, OT, SPH) involved in the isiXhosa clinical communication course were approached to participate in the survey. A total of 58 students participated in the study. In HN, there was a total of 27 students, and 26 participated in the study. In OT, there were 33 students, of whom 25 participated. In SPH, there were seven students, and all seven participated in the study. However, not all students were observed. Of the 26 Human Nutrition students, 11 (42%) students were observed, while of the 25 Occupational Therapy students, 16 (64%) students were observed. Students were observed during orals with simulated patients. When students do orals, they are divided into two groups. For this reason, only one of these two groups could be observed; this explains the relatively low numbers for observations. All 7 (100%) Speech-Language and Hearing Therapy students were observed. For the purpose of observations, convenience sampling were used.

Students included both Afrikaans and English speaking individuals from both genders.

4.6 Methods of data collection

Qualitative data was gathered by means of individual interviews, observations, as well as document analysis. Furthermore, both quantitative data and qualitative data were gathered by means of a student survey. The following forms of data were utilized to answer the four research sub-questions.

Sub-question 1 (Section 4.2)

The status quo of the current isiXhosa course presented to students was determined by performing a document analysis of the course objectives, outcomes, outlines and other relevant documentation.

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This was done in order to determine whether these objectives, outcomes and content of the course outlines were aligned with the communicator competency of the CanMEDS framework.

Sub-question 2 (Section 4.2)

In order to answer this sub-question, questionnaires (Addendum B) were distributed among students in order to determine students' perceptions regarding the isiXhosa clinical communication course. These questionnaires were distributed at FMHS outside students' class times. For HN, 26 questionnaires were provided, and all questionnaires were completed. For OT, 25 questionnaires were provided and all questionnaires were completed. The response rate was thus 100% for these two groups. For SPH, eight questionnaires were provided, and all eight questionnaires were completed. However, one questionnaire could not be used due to the fact that the student was a mother tongue speaker of isiXhosa. The response rate was thus 87.5% for SPH.

Sub-question 3 (Section 4.2)

Individual interviews (Addendum C) with two staff members in the current isiXhosa communication course were conducted in order to answer sub-question 3. The interviews produced qualitative data. Interviews allowed for respondents to raise and discuss issues which the interviewer had not necessarily included in the interview schedule or anticipated (Corbetta, 2003; Gray, 2004; Wengraf, 2001). One interview was conducted at FMHS, while the other interview was conducted at Stellenbosch University (main campus). Both interviews lasted between 20-25 minutes.

Sub-question 4 (Section 4.2)

In order to answer sub-question 4 observations of clinical consultations of Occupational Therapy, Speech-Language and Hearing Therapy, and Human Nutrition students with simulated patients were conducted. An observation schedule (Addendum D) with the modified CanMEDS framework communicator competency as basis was utilised. Students were observed in a simulated environment, while conducting a consultation with a simulated patient. The environment was created to reflect a real life situation. To reflect a real life situation, students were provided with a specific scenario which they had to prepare, and a simulated patient was trained accordingly. Simulation was used due to the fact that it is more difficult to observe students within the clinical

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context, and when real patients are consulted ethical issues around observations arise. These consultations occurred in the Clinical Skills Laboratory at the Faculty of Medicine and Health Sciences.

4.7 Data triangulation

Triangulation within research is the use of a combination of either two or more theories, data sources, methods or investigators in one study of a single phenomenon in order to allow for diverse viewpoints or perspectives to shed light on a specific topic (Olsen, 2004). Data triangulation is used to increase the validity of research findings. However, triangulation does not only ensure validity, but it is also aimed at deepening and widening one's understanding of the research data (Yeasmin & Rahman, 2012) gathered.

Triangulation can be used in quantitative, qualitative or mixed-method studies (Yeasmin & Rahman, 2012). Mixing of methods is a more accurate form of triangulation (Olsen, 2004).

The above-mentioned discussion regarding triangulation can be represented diagrammatically as follows (Fig 4-1):

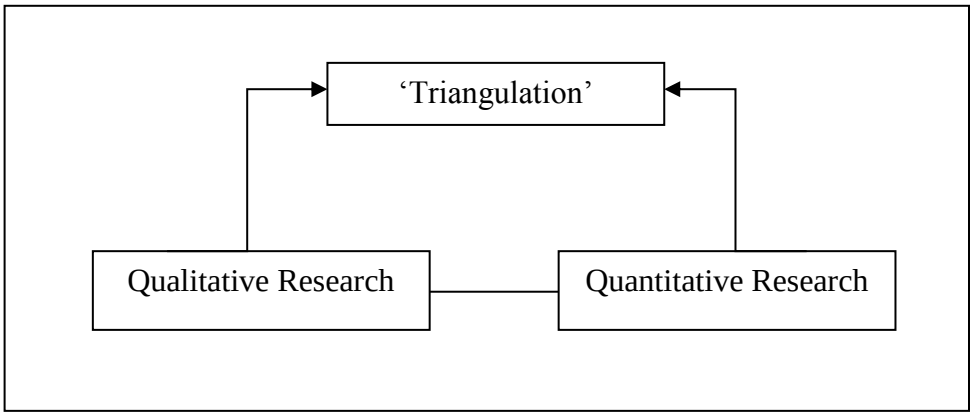

Figure 4-1: Basic Triangulation Research Model

Denzin (1970) explained four forms of triangulation: 1) data triangulation, i.e. to retrieve data from various sources in order to form one body of data; 2) investigator triangulation, i.e. the use of multiple investigators instead of just one investigator in an attempt to gather and interpret

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information; 3) theoretical triangulation, i.e. the use of more than one theoretical position in the interpretation of data; and 4) methodological triangulation, i.e. using various research methods or data collection techniques such as interviews, observations, questionnaires, and documents (Yeasmin & Rahman, 2012; Kennedy, 2009).

The type of triangulation employed is dependent on the purpose of the research study and it is possible that more than one type of triangulation can be used in the same research study. For the purpose of this study, methodological and data triangulation were used. I used a combination of questionnaires, interviews, document analysis, as well as observations to collect my data, and I also collected the data from various sources, namely three different groups of students and lecturers.

Four reasons can be given for undertaking data triangulation. Firstly, it is for the purpose of enriching, i.e. the information from various instruments adds value to one another by explaining different aspects. Secondly, it is for the purpose of refuting, i.e. a set of options disproving a hypothesis generated by another set of options. Thirdly, it is for the purpose of confirming, i.e. a set of options confirming a hypothesis generated by another set of options. Fourthly, it is for the purpose of explaining, i.e. a set of options shedding light on unexpected findings (Kennedy, 2009).

Triangulation in this particular study was used for enriching, explaining, and confirmatory purposes (Kennedy, 2009). There are various benefits of the use of triangulation for confirmatory purposes. One of these benefits is that qualitative results can be validated by quantitative studies, and vice versa. Furthermore, quantitative research instruments can be validated. In addition, shortcomings related to a single-method, single-observer and single-theory bias can be overcome, and can thus be applied to confirm the research results and conclusions (Yeasmin & Rahman, 2012).

The use of triangulation provided the researcher with several opportunities. It minimized the inadequacies of single-source research. The impact of bias was reduced by using more than one data collection source and, in turn, richer and more comprehensive information was obtained (Yeasmin & Rahman, 2012).

The process of data triangulation contributed to the researcher's confidence in the results obtained from this study.

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4.8 Data collection

The participants in this research study were selected based on their involvement in the isiXhosa clinical communication course concerned (refer to Chapter 3 for discussion of the course). Prior to data collection, an introduction to the study was given to the participants during which the researcher introduced herself and explained the purpose of this study, as well as their role in the study. Following this introduction, a consent form was provided to the participants. The instruments used in this study for data collection are a questionnaire, an observation schedule, and semi-structured interviews. A description of these instruments will follow.

After giving the introduction and consent form, a questionnaire (Addendum B) was given to the students to complete. The questionnaire consisted of two sections: 1) demographic questions, and 2) items on communicator competencies. Section 2 further consisted of five questions requiring students to self-assess the extent to which the isiXhosa clinical communication course contributed to developing their ability to communicate with patients. These five questions were based on the competencies of the Communicator role in the CanMEDS framework. Students were asked to read each statement and then indicate on a four-point Likert scale the extent to which the isiXhosa clinical communication course contributed to developing their ability to communicate with patients. The Likert scale ranged from fully, to a considerable extent, somewhat, to not at all. After every statement, students were requested to motivate their responses. By obtaining students' responses from the questionnaires, it could be determined whether the isiXhosa clinical communication course serves the needs of the HN, OT and SPH students (evaluation of process), what the unmet needs of the students are (evaluation of need), whether students are more skilful and knowledgeable (evaluation of outcome), and whether students have a positive attitude towards the communication course (evaluation of outcome).

The data obtained from the questionnaires were then analysed and interpreted. The research design made provision for the possibility to conduct semi-structured focus group interviews with participants to clarify uncertainties and probe certain issues highlighted by the survey responses in order to gain deeper insight into the process and challenges of developing key competencies of the communicator. However, students' responses to the questionnaire were quite clear and no issues were highlighted that required further probing. For this reason, focus group discussions were not held.

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In addition to the survey, students were observed by the researcher while interacting with patients in a simulated environment. Students were observed in order to determine whether they could sufficiently engage with an isiXhosa speaking patient, i.e. students' level of knowledge and skills were evaluated (evaluation of outcome). The observation schedule (Addendum D) was based on the competencies of the Communicator role in the CanMEDS framework. This schedule comprised seven sections. In section one, the observation session details were recorded. Section 2-6 included the communicator competencies, and section 7 provided for general comments regarding student behavior. In sections 2-6, the communicator competencies were rated as either demonstrated or not demonstrated, with a section for comments. The ratings were done by the researcher. The comments were also written by the researcher during observations of students. Seeing that the researcher understands isiXhosa, she could follow the interactions between simulated patient and student, and could thus do the ratings and write comments.

In addition to the student survey and observations, lecturers involved in the clinical communication course were invited for a semi-structured interview (Addendum C). The researcher first introduced herself and explained the purpose of the study, and then explicated their role as lecturers in the research study. Following this introduction, a consent form was provided to the staff members.

The semi-structured interviews consisted of four questions which required staff members to 1) describe students' attitude towards the clinical communication course, 2) explain how they, as lecturers, are attempting to meet the requirements of the communicator competencies of the CanMEDS framework through their teaching of the course, 3) motivate to what extent the clinical communication course is effective in capacitating students to meet the requirements of the communicator role, and 4) provide recommendations of how the communication course could be changed to be more effective in this regard. The interviews were recorded and then transcribed. Data obtained from the interviews could establish whether services were delivered as intended (evaluation of process), as well as attitudinal changes within students (evaluation of outcome).

Furthermore, the documentation, i.e. the course outlines and course manuals used in the isiXhosa clinical communication course were thoroughly studied. The documentation were obtained from the lecturers involved in the course. Notes were made regarding the outcomes of the isiXhosa clinical communication course, as well as the clinical content taught to students. Information from the documentation could determine whether students acquire sufficient knowledge and

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vocabulary, or whether there is a need for more sufficient content in order to enable students to communicate in the clinical context.

All correspondence with the involved participants was carried out by personally interacting with the participants.

The data obtained from the two respective participant groups (students and lecturers) were analysed in order to determine whether the current isiXhosa clinical communication course is effective in enabling students to engage with isiXhosa speaking patients in clinical consultation. Conclusions were formulated and the findings were further used to make possible recommendations for future.

4.9 Data analysis

The data gathered by means of individual interviews, clinical observations and the document analyses were compared with the requirements of the communicator competency of the modified CanMEDS framework. This comparison enabled the researcher to identify gaps in the course.

The semi-structured interviews of the lecturers were recorded and the recordings were transcribed. The responses were then analysed and interpreted according to the different topics that were raised. While listening to the recorded interviews, codes were created to describe the text that was examined; descriptive coding (Gibbs & Taylor, 2010) was thus followed. The data were coded with themes identified with *a priori* ideas (Gibbs & Taylor, 2010), i.e. the data were coded according to the questions and topics from the interview schedule.

The responses obtained from the closed-ended questions (Likert scale) in the questionnaire were grouped according to the extent in which the isiXhosa clinical communication course contributed to developing the respective competencies and percentages were calculated. This information is presented in graph form in Chapter 5. The information from the open-ended questions were analysed and documented. The data were coded using inductive analysis (Thomas, 2006). Inductive analysis refers to "approaches that primarily use detailed readings of raw data to derive concepts or themes through interpretations made from the raw data by an evaluator or researcher" (Thomas, 2006: 238). An inductive approach was used to analyse the data of the questionnaires in order to allow for new findings to emerge from the themes inherent in the data of the questionnaires

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(Thomas, 2006). During the process of analysing the data obtained from the questionnaires, the raw text data were summarised from which themes derived. Thereafter, clear links were established between the research objectives and the summary findings (Thomas, 2006).

A thorough analysis of the documentation obtained from the program coordinator of the current isiXhosa communication course was made. The focus was specifically on the course outlines and the isiXhosa manuals provided to students. The course outlines were studied to determine what the isiXhosa course intends to present to students in terms of lectures and assessment, as well as in terms of what students should be able to do upon completion of the isiXhosa course (outcomes). Furthermore, the isiXhosa manuals were studied to determine the type of content that students learn. The information gathered from this document analysis was used to determine whether the isiXhosa content is sufficient in meeting the needs of the communicator competency of the CanMEDS framework.

While observing clinical consultations, an observation schedule was completed for every observation, and in addition, notes were made which were then analysed. These observations were compared with the responses of the students and lecturers.

4.10 Ethical considerations

Informed consent

Ethical approval for the study was obtained from the Human Research Ethics Committee at FMHS. Furthermore, institutional permission, as well as permission from the Speech-Language and Hearing Therapy Department, Human Nutrition Department and Occupational Therapy Department were also obtained in order to retrieve information from all the relevant stakeholders, i.e. 1) students from the Speech-Language and Hearing Therapy Department, Human Nutrition Department and Occupational Therapy Department, 2) the lecturers involved in the isiXhosa clinical communication course due to the fact that lecturers were interviewed and students were observed while interacting with an isiXhosa speaking simulated patient.

The nature of the research was explained to the participants and they also received a participant information leaflet (Addendum E) explaining the purpose of the study including what would be required from them as participants, how confidentiality of their responses would be ensured, and

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how the results would be used in future. Participation was voluntary and informed consent was obtained from the participants. Participants were free to withdraw from the study at any given time, without any consequence to them.

Questionnaires were treated with confidentially by not asking students to provide any of their personal details such as names or student numbers. In this way, when data were analysed, the researcher did not know to whom the responses belonged. Only the researcher had access to all the responses of the participants, as it was password protected on the computer. The answers to the questionnaires and interviews were coded and this data was saved with a secured password.

The email address and telephone number of the researcher were made available to the participants for any enquiry.

Anticipated benefits

It was anticipated that the results of this study would provide sufficient and appropriate information to determine whether the current isiXhosa communication course contributes towards enabling students to fulfil the competency of communicator according to the modified CanMEDS framework. This may ultimately result in recommendations for the improvement of the course.

4.11 Limitations of study

Some limitations were experienced during this research study. The ideal would have been to observe students while interacting with isiXhosa speaking patients in the hospital. However, due to logistical reasons, this was not possible. Therefore, students had to be observed within a simulated environment. Furthermore, it would have been ideal to observe students more than once, but due to time constraints this could not be done and thus students were only observed once.

It is important to note that observations took place in simulation, and not in a real life context. Simulated patients were trained according to a specific scenario that students had to prepare. This means that observations were restricted in terms of students using limited knowledge during their consultations with simulated patients. Whether the isiXhosa clinical communication course meets the requirements of the communicator competency could thus, in this regard, only be determined on one aspect of the content that students were exposed to during the course.

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Furthermore, the researcher did consider the fact that the lecturers concerned might have been biased, causing them to view the isiXhosa communication programme in a more positive light.

4.12 The role of the researcher, validity and reliability of the research

The isiXhosa clinical communication course forms part of a broader language course which consist of an isiXhosa and an Afrikaans component. The researcher is part of the broad language course as she is a lecturer in the Afrikaans component. The fact that the researcher collected the data on a course that she has intimate knowledge of, seeing that she teaches an adjunct course, could cause possible bias. In order to minimize any potential bias and to, as far as possible, stay neutral in the process of data collection, the following procedures were followed: firstly, the credibility of the study was addressed by ensuring that the study measured what was actually intended to be measured. Furthermore, to promote confidence in the data, triangulation occurred, i.e. the use of observations, questionnaires, and interviews (Shenton, 2004). Secondly, the dependability (reliability) of the study was addressed. Reliability was ensured by providing a detailed description of the processes followed to conduct this study. Therefore, if this study was to be replicated, a replicate study could create a similar context, use similar participants and employ similar data collection and analysis methods (Shenton, 2004).

4.13 Conclusion

The choice of collecting both qualitative and quantitative data (Plowright, 2011) proved to be suitable for this research study which was an evaluation study of a single programme, as optimal results could be obtained. By triangulating the research findings, the results could be validated, and the researcher could gain an in-depth understanding of the research data gathered.

This study was an evaluation study. Three types of evaluation were followed, namely evaluation of need, evaluation of process, and evaluation of outcomes. Evaluation of need was done by doing a document analysis of all available course material, as well as through the questionnaires provided to students. Evaluation of process was done by means of interviews with lecturers, as well as questionnaires provided to students. Finally, evaluation of outcome was done by data collected from the questionnaires, interviews and observations of students.

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The next chapter presents the findings of the research done on the extent to which the isiXhosa clinical communication course at Stellenbosch University Faculty of Medicine and Health Sciences satisfies the communicator competency requirements of the modified CanMEDS framework.

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5 DATA ANALYSIS AND RESEARCH FINDINGS

5.1 Introduction

In Chapter 4, the process of data collection and data analysis for this study was described. The aim of the data collection and data analysis was to answer the research question: *To what extent does the isiXhosa clinical communication course of the Faculty of Medicine and Health Sciences at Stellenbosch University in Speech-Language and Hearing Therapy, Human Nutrition, and Occupational Therapy satisfy the communicator competency requirements of the modified CanMEDS framework?* Four forms of data were utilized in an attempt to effectively answer the research question. Firstly, a document analysis was performed in an attempt to determine the extent to which the documentation of the isiXhosa course provides evidence of meeting the requirements of the modified CanMEDS communicator competency. Secondly, a survey was done among students in order to determine their perceptions of the extent to which the isiXhosa course equips them to meet the requirements of the communicator competency. Thirdly, students were observed during consultations with simulated patients in an attempt to provide evidence of the extent to which they meet the requirements of the communicator competency. Lastly, lecturers involved in the isiXhosa course were interviewed to establish the extent to which they, as lecturers, attempt to meet the requirements of the communicator competency through their teaching.

This chapter will present the findings obtained from the different methods of data collection. This will be followed by an analysis and discussion of the findings. Finally, conclusions will be drawn.

It is important to understand that the isiXhosa clinical communication course is one course with different applications in the different disciplines (i.e. Human Nutrition, Occupational Therapy, and Speech-Language and Hearing Therapy). For this reason the term ‘course’ will be used throughout.

5.2 Overview of isiXhosa course

For the purpose of this research project, the focus is on the isiXhosa clinical communication course implemented for HN, OT, and SPH students at the Faculty of Medicine and Health Sciences of Stellenbosch University.

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The aim of the language course for these respective programmes is to develop students' communication skills in order for them to communicate effectively in a clinical setting. Furthermore, it attempts to enable students to understand how cultural differences between people will affect the way they communicate with one another. More specifically, the objectives are to 1) provide the necessary linguistic structures that will enable students to make themselves understood and apply their language proficiency to the fullest, 2) apply linguistic knowledge through interactive and task-based opportunities, 3) provide new understandings to a range of cultural and conventional practices so that students are aware of how to use language and respond appropriately, and 4) engage students with isiXhosa speaking patients.

By the end of this course, students should be able to 1) initiate and maintain a meaningful and intelligible conversation in isiXhosa with patients in a clinical setting, 2) understand, know and apply acquired vocabulary and language structures in context, 3) use basic isiXhosa reading and writing skills, and 4) demonstrate socially appropriate communication skills when interacting with an isiXhosa speaking patient, given the setting, topic and relationships among people.

It is important to be cognisant of the fact that the outcomes of the isiXhosa course specified above differ from the outcomes specified in the communicator competency role of the CanMEDS framework (section 3.2). Evaluating the isiXhosa clinical communication course had amongst other the purpose of determining whether the outcomes of the course enable students to meet the requirements of the communicator competency role.

The content of the isiXhosa clinical communication course is discipline specific, i.e. students acquire knowledge within their respective fields which they will be able to apply during consultations with patients / clients. During the first year of the isiXhosa course, students are first exposed to content regarding introductions (such as greetings and developing rapport) and case history before being exposed to discipline specific content. The content regarding introductions and case history are the same for all the undergraduate programmes during the first semester of the first year of students' enrolment in the isiXhosa course. From the second semester onwards, the content will start to differ according to the respective undergraduate programmes (as illustrated in table 5-1). In each of the undergraduate programmes, the isiXhosa course forms part of a practical module. The content of the isiXhosa clinical communication course thus correlates of the practical module in each of the respective undergraduate programmes. Therefore, each year group

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will have specific isiXhosa content according to the practical module. The following table provides an overview of the isiXhosa content taught in the respective undergraduate programmes (take note that students only receive the isiXhosa course for a limited number of years as described in Chapter 2):

Table 5-1: Overview of content of the isiXhosa clinical communication course in the respective undergraduate programmes

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

The course has four components, i.e. listening and speaking skills, basic reading and writing skills, an e-learning platform and a cultural component. These four components are the same for all three programmes (HN, SPH, OT). The listening and speaking skills are developed through a range of communicative-based language learning techniques and activities preparing students for interaction with patients.

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Although the primary focus is on communicating meaningfully and intelligibly, the reinforcement of students' speaking and listening skills is also supported by the inclusion of numerous reading and writing tasks.

The e-learning component consists of text-to-speech and task-based activities and quizzes which are based on the content taught during contact sessions. The e-learning is designed to complement the contact sessions, and not to replace them.

The cultural component gives students insight into a range of cultural practices and values relevant to family, the community and society. More specifically, students are introduced to respect, politeness, relationships, language and cultural sensitivity, as well as the impact of culture and language on different language groups.

Continuous assessment is the preferred approach to assess students. Students are assessed by means of e-tasks, oral assessments, as well as a written assignment. The e-tasks comprise of translation, type-in and dialogue, which test students' reading and writing skills. The assessment strategies are the same for HN, SPH and OT students.

For the purpose of oral assessments, students are required to interact with a simulated patient. During this assessment, students' performance of a clinical task and their level of communicative competence are evaluated. Simulated patients are also required to, in turn, assess the students as they are ideal to provide feedback on the intelligibility of students' communication.

Students from each department (HN, OT, SPH) are divided into two groups for a maximum of 20 students per lecturer. There are slightly more than 20 students in the Occupational Therapy second year class as this tends to be a bigger group than the rest. The idea is to be able to provide more individual attention to each student in class. In small classes it is easier to determine whether students understand the work or not. It is also easier to have interactive activities in class in which students can participate.

Students receive isiXhosa once a week during the first semester and the second semester for only 1h30mins. Table 5-2 gives an indication of the number of weeks per semester. As indicated in Table 2-1 (Chapter 2) the Human Nutrition and Occupational Therapy students receive the isiXhosa clinical communication course for two years, while the Speech-Language and Hearing

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Therapy students receive it for three years. Human Nutrition students receive isiXhosa during their second (HN II) and third (HN III) year of studies, Occupational Therapy students receive isiXhosa during their second (OT II) and third (OT III) year of studies, and Speech-Language and Hearing Therapy students receive isiXhosa during their second (SPH II), third (SPH III) and fourth (SPH IV) year of studies. Time with students is thus limited. Contact sessions with students from all three disciplines are complemented with e-learning lessons throughout the duration of the isiXhosa clinical communication programme (as discussed in section 5.2).

Table 5-2: Number of weeks per semester for each discipline

	HN II	**HN III**	**OT II**	**OT III**	**SPH II**	**SPH III**	**SPH IV**
First semester	±18 weeks	±18 weeks	±19 weeks	±17 weeks	±12 weeks	±10 weeks	±8 weeks *
Second semester	±12 weeks	±13 weeks	±12 weeks	±10 weeks	±14 weeks	±9 weeks	

* Note that SPH IV students are divided into three groups. Each group gets isiXhosa for eight weeks. These eight weeks might therefore not necessarily fall in the first or second semester per se, depending on their rotation blocks.

5.3 Overview of data

Three groups of students (n = 58) and one group of lecturers (n = 2) participated in the study. The student groups included third-year Human Nutrition (n = 26) students, third-year Occupational Therapy (n = 25) students, and fourth-year Speech-Language and Hearing Therapy (n = 7) students. Only seven Speech-Language and Hearing Therapy students could be used due to the fact that they are divided into three groups who are on clinical rotations throughout the year. Therefore, the whole group do not receive isiXhosa classes at the same time.

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All participants were involved in the isiXhosa clinical communication course at Stellenbosch University Faculty of Medicine and Health Sciences. The Human Nutrition and Occupational Therapy students received the clinical communication course for two years, while the Speech-Language and Hearing Therapy students received it for three years.

In order to ensure triangulation of the data, questionnaires, interviews and observations were used as research instruments. These instruments were all designed based on the Communicator competency of the CanMEDS framework. A document analysis of all relevant course material was also performed in order to determine whether the isiXhosa clinical communication course meets the requirements of the Communicator competency.

Of the 58 students, 28 (48%) were English speaking, 24 (41%) were Afrikaans speaking, 4 (7%) were bilingual, and 2 (4%) were Mandarin speakers. Furthermore, 45 (77%) were white, 10 (17%) were coloured, 1 (3%) was Asian, and 1 (3%) was Indian.

The student survey had a response rate of 100%. However, not all students were observed. The approach of convenience sampling was thus used. Of the 26 Human Nutrition students, 11 (42%) students were observed, while of the 25 Occupational Therapy students, 16 (64%) students were observed. All 7 (100%) Speech-Language and Hearing Therapy students were observed.

5.4 Analysis of the course material

A document analysis was done of all the documentation relevant to the isiXhosa clinical communication course for Human Nutrition, Occupational Therapy, and Speech-Language and Hearing Therapy students. The analysis was done of the course manuals, as well as the course outlines which provide students with guidelines about the course. Next, an analysis of what the isiXhosa clinical communication course for each group of students entails, is given.

5.4.1 Course outline

In the outline of the course it is explicitly stated that Stellenbosch University Faculty of Medicine and Health Sciences is committed to developing students' clinical communication skills to bridge cultural and language divides between isiXhosa speaking patients and the healthcare professional. For students to effectively communicate in isiXhosa and to understand how cultural differences

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between people affect the way they communicate with one another, this course attempts to: 1) provide the necessary linguistic structures that will enable students to make themselves understood and apply their current proficiency to the fullest; 2) apply linguistic knowledge through interactive and task-based learning opportunities; 3) provide new understandings into a range of cultural and conventional practices so that students are sensitively aware of how to use and respond appropriately; and 4) engage students with isiXhosa speaking patients (Language Centre, 2016).

For each of the three groups of students completing the isiXhosa clinical communication course, the outcomes stated that students should be able to:

- Initiate and maintain a meaningful and intelligible conversation in isiXhosa related to general hospital and clinical specific situations;
- Understand, know and apply acquired vocabulary and language structures in context;
- Use basic isiXhosa reading and writing skills;
- Demonstrate socially appropriate communication skills when interacting with an isiXhosa speaking patient, given the setting, the topic and relationships among people.

Two components are focused on during the course, namely listening and speaking skills, and basic reading and writing skills. The listening and speaking skills are developed through numerous communicative-based and interactive exercises in order to advance students' isiXhosa language proficiency. Furthermore, the learning of isiXhosa is facilitated through introducing a range of isiXhosa language grammatical structures. Even though the primary focus of this course is on communicating meaningfully and intelligibly within a clinical context, numerous reading and writing activities are included in order to develop the basic reading and writing skills of students.

Apart from the above-mentioned skills, the course outlines further stated that students will also be introduced to the cultural aspect of the language, i.e. cultural practices and values relevant to family, community and society. The focus will specifically be on 1) respect and politeness, 2)

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relationships, 3) gender specific customs and rituals, 4) language, cultural sensitivity and bias, and 5) understanding the impact of culture and language on different language groups.

It is important to note that the content taught to students is discipline specific. This means that the content is tailor-made for each discipline involved, i.e. HN, OT, and SPH, as illustrated below. Normally, during the first semester of the first year of students' involvement in the isiXhosa communication course, the content is the same across the board (see below). After the first semester and up to students' completion of the isiXhosa communication course, the content differs for HN, OT, and SPH. Upon completion of the isiXhosa clinical communication course, students are required to have acquired knowledge within their respective fields and be able to apply it during consultation with patients. The content for each discipline will now be discussed.

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Table 5-3: Summary of isiXhosa content for each discipline

	Content
Human Nutrition	Develop a rapport by exchanging greetings, doing introductions, and bidding farewell Develop a case history (e.g. questions about accommodation, personal details, family background, employment, lifestyle habits) Provide directions to particular venues in a hospital setting Engage in systemic questioning and provide a diet history accordingly Do a meal follow-up Do an anthropometrical and clinical examination Conduct interviews on healthy and non-healthy food types
Occupational Therapy	Develop a rapport by exchanging greetings, doing introductions, and bidding farewell Develop a case history (e.g. questions about accommodation, personal details, family background, employment, lifestyle habits) Provide directions to particular venues in a hospital setting Conduct an interview on weekly and weekend routines (in first and third person) Conduct an interview on disability grants (physical and intellectual) Conduct interviews associated with range of motion on different body parts
Speech-Language and Hearing Therapy	Develop a rapport by exchanging greetings, doing introductions, and bidding farewell Develop a case history (e.g. questions about accommodation, personal details, family background, employment, lifestyle habits) Provide directions to particular venues in a hospital setting Do an oral-sensory motor examination Do an articulation screening and hearing screening Engage in consultations regarding receptive diagnostic tests and print awareness Engage in consultations regarding neuro-screening (language) assessment procedures

From the information provided in Table 5-3 it is clear that the content regarding introductions, case history and directions are the same for all three disciplines. However, in terms of clinical content, the content for each discipline differ according to the needs of each discipline.

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5.4.2 Outline of course manuals

The manuals provided to students were thoroughly studied and compared with the outcomes specified in the course outlines. The content above (Table 5-3) which is specified in the course outlines for the three respective disciplines, is covered in the manuals. The content in the manuals is divided according to what the students would need to be able to communicate with patients in each specific year. The manuals provided are thus designed with the focus on teaching for specific purposes (refer to Chapter 3, section 3.6.1.2), i.e. the manuals are specifically designed for each discipline involved with a very definite focus. Due to the fact that the manuals are discipline specific, they contribute towards enabling students to use the content in their respective fields (Chapter 3, section 3.6.1.2).

Each lesson in the manuals starts with a dialogue which is an example of how a consultation could possibly occur. It is thus evident that the manuals expose students to problems encountered with patients in the clinical setting (refer to description of SPICES model in Chapter 3, section 3.6.1.3). Following the dialogue is a list of vocabulary related to the content of each specific lesson. After the dialogue and vocabulary, various activities follow. These activities include translations, formulating sentences, filling in missing words, matching correct responses to answers, etc. Furthermore, grammatical rules, e.g. past tense, negative, future tense, etc. are explained. Each lesson in the manuals follows the same pattern. Student learning is an active process and therefore it is important to enable students to actively engage in the subject matter (as described by the SPICES model in Chapter 2, section 2.3). The activities in the manuals thus allow students to actively engage in the particular subject matter which develops students' critical thinking and problem-solving skills.

In Chapter 3 (section 3.6.1.4) 'constructive alignment' was discussed. It was specifically stated that there should be an alignment between the outcomes specified, the assessment, the way in which the assessment supports the learning outcomes, and the activities designed. In terms of the isiXhosa course, it is clear that the content and activities in the manuals address the outcomes as specified in section 5.4.1. There is thus an alignment between the content, activities and outcomes.

Furthermore, in Chapter 3 (section 3.2) the various key competencies informing the CanMEDS communicator competency were outlined. It is thus clear that there are certain competencies which

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students should develop in order to "effectively facilitate the carer-patient/carer-client relationship and the dynamic exchanges that occur before, during and after interventions" (Faculty of Medicine and Health Sciences, Stellenbosch University, 2013:5). From the document analysis it was evident that the communicator competency is developed to a certain extent.

5.5 Responses and student observations

Seeing that both the questionnaire (Addendum B) and observation schedule (Addendum D) were designed according to the communicator role in the CanMEDS framework, the datasets were analysed together. Student responses from all three disciplines were combined and analysed as one dataset due to the fact that they all had to, in terms of my research question, satisfy the same requirements of the communicator role of CanMEDS. Also, the data showed that there weren't significant differences between the responses of students from the three disciplines.

Five key competencies of the communicator role were explored. These five key competencies were as follows: 1) Develop rapport, trust and ethical therapeutic relationships with patients; 2) Accurately elicit and synthesize relevant information and perspectives of patients and families; 3) Accurately convey relevant information and explanations to patients; 4) Develop a common understanding of issues, problems and plans with patients to develop a shared plan of care; and 5) Convey effective oral and written information about a medical encounter. In the questionnaires, students were required to indicate their views on a four-point Likert scale (Chapter 4, section 4.8), and answer open-ended questions. The responses obtained from the Likert-scale will be presented in graph form, and the answers obtained from the open-ended questions will be given as quotations in italics.

It is important to point out that the students were observed in simulation with trained simulated patients. Students were only required to perform one aspect of the content that they were taught, i.e. OT students did disability grants, HN students did an anthropometrical and clinical examination, and SPH students did neuro-screening (see Chapter 3, Table 3-1 for content layout). Students' survey responses, as well as the observation results are presented in the following section.

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5.5.1 Competency 1: Develop rapport, trust and ethical therapeutic relationships with patients

Survey responses

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

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

The following graph (Figure 5-1) demonstrates that the majority of students believed that they were to a considerable extent able to develop rapport, trust and relationships with patients:

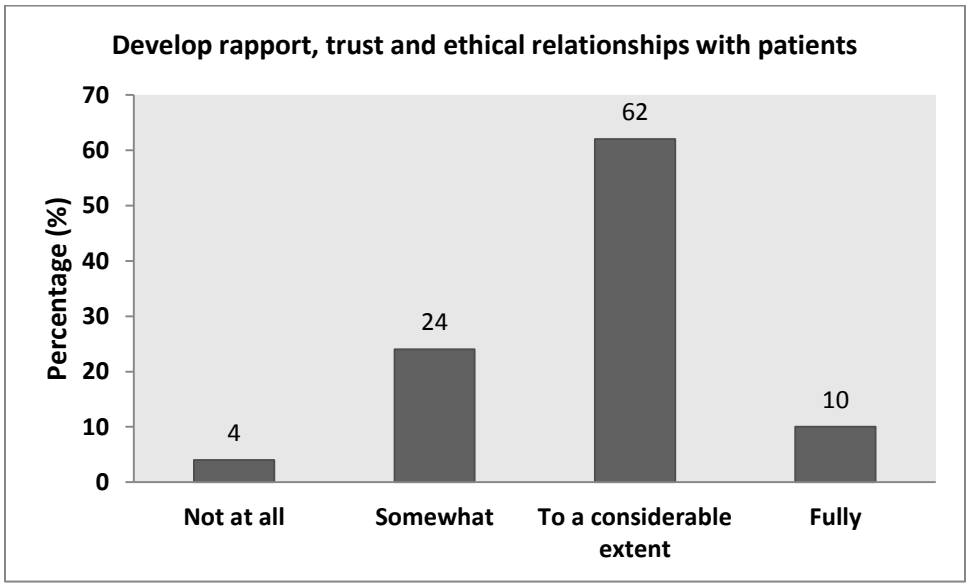

Figure 5-1: Self-perceived competency in developing rapport, trust and ethical relationships

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Even though most students felt that they were able to develop rapport and trust to a considerable extent, some students indicated that the programme only enabled them to acquire basic vocabulary to communicate on a basic level; however, they could not fluently communicate with patients in isiXhosa. Having only basic vocabulary became a problem as students were not always able to understand patients' questions or responses. From students' responses it is clear that they were very dependent on what had been taught in class, as they stated that they would not be able to understand if patients responded differently from what they had been taught. They were able to ask questions, but could not respond to patients' responses, because they were not always sure what the patient had responded. Students mentioned that in real life patients tend to answer questions differently, and this variety of responses is not covered in class. "*In real life patients often answers things that was not covered in class; then one cannot really understand".* Therefore, students do not always feel confident in approaching an isiXhosa patient.

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

Even though students were not always able to understand patients, they were able to inform the patients in isiXhosa that they had only basic knowledge of the language and that they did not understand everything that the patient said.

Observations of the simulated patient encounters

During observations of students engaging in consultations, it was clear that students could effectively develop a rapport with the simulated patients. Students were able to establish a positive relationship by introducing themselves, explaining their student role, asking permission to ask the patient questions and ensuring them of the confidentiality of the information. Students also

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demonstrated socially appropriate behaviour by addressing patients properly and greeting them with a handshake. When patients indicated that they were not feeling well, students were able to empathise with them. By developing rapport and establishing a positive relationship, patient-centeredness was partially demonstrated as respect was shown towards the patients. It was, however, not fully demonstrated due to the fact that patient-centered communication must be enabled through shared decision-making which is essential for formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care. Students were unable to formulate diagnosis, deliver information, and facilitate a shared plan of care (see sections 5.5.2, 5.5.3, 5.5.4, 5.5.5, 5.7).

Students could engage with patients using the knowledge and vocabulary they had learnt. However, students were not always involved in actively listening to their patients. They were merely trying to get through the necessary questions without really paying attention to the responses of the patients.

With regard to demonstrating flexibility in the application of communication skills, it was evident in the observations that students seemed to struggle. When patients did not understand, students could not clarify what had been said. This caused a breakdown in communication between the student and patient. Students did not possess strategic competence, i.e. students did not know how to enhance the effectiveness of communication or to repair and compensate for breakdowns in communication due to gaps in their knowledge.

5.5.2 Competency 2: Accurately elicit and synthesize relevant information of patients and families

Survey responses

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

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had not reached that level of comprehension and thus did not feel *"fluent enough to be able to get the relevant information"*.

Students mentioned that they needed to do very intensive interviews and that not all of the relevant vocabulary was covered in class. Therefore, in some instances students could simply not understand the patients.

Apart from not having the necessary vocabulary and knowledge, students found that isiXhosa patients tend to speak very fast and pronounce words differently from how they were taught which made understanding patients' responses difficult. This left students unable to ask further questions in order to elicit relevant information needed. A student commented that *"it is difficult to get all the relevant information compared to if you were asking it in your home language"* which sometimes caused *"the depth and the extent of the information to be compromised"*.

Figure 5-2 demonstrates that the majority of students were limited in their ability to elicit and synthesize relevant information:

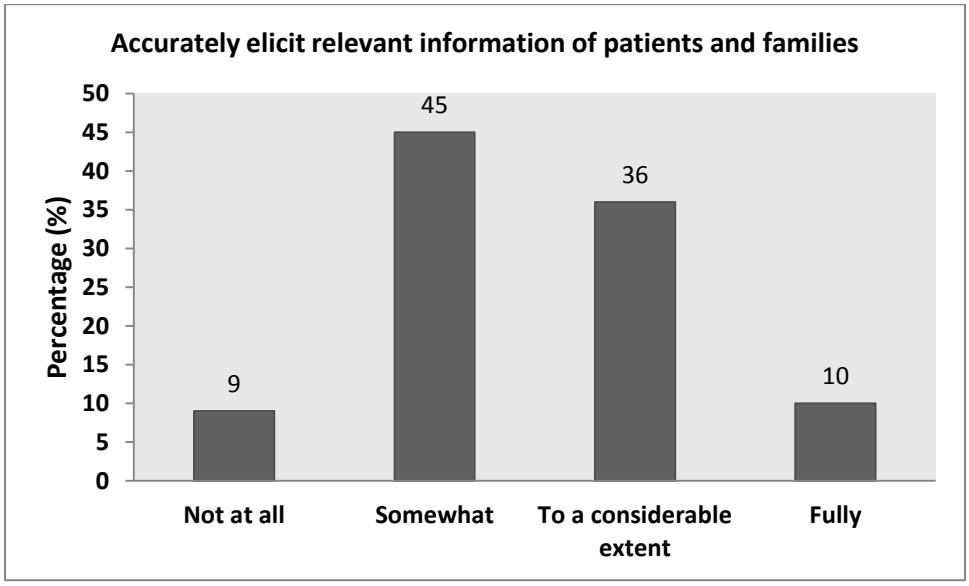

Figure 5-2: Self-perceived competency in eliciting relevant information

Even though students mentioned that they did not feel confident to accurately elicit relevant information, they did feel competent with applying the vocabulary that they had learnt. Even with

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limited vocabulary, it was still *"an advantage being able to ask for information in the patient's language"*. Students also indicated that there might be words or phrases that they would not understand, but they would still be able to identify some of the words and would try to construe the meaning of what was said. This had the benefit that when patients saw that they were trying to speak their language, they were more cooperative and patient with the students.

Observations of the simulated patient encounters

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

However, due to their limited vocabulary students could only probe for more detail to a certain extent in an attempt to clarify uncertainties. Students were mostly able to ask 'yes' and 'no' type of questions or provided patients with some options from which they could choose; this left no room for further explanations.

It was observed that students were very sensitive in their approach when probing for information from patients. Students would always ask permission before examining the patient. When students didn't understand, they would ask patients to show them what the problem was. In this way, even with limited vocabulary, students tried to clarify uncertainties, even if this was not always successful.

It is thus clear that, even though students were sensitive towards patients, they had difficulty in accurately eliciting relevant information from patients.

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5.5.3 Competency 3: Accurately convey relevant information and explanations to patients

Survey responses

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

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

Students further mentioned that patients often gave answers that they did not understand. This created a language barrier between student and patient. They also found it difficult to try and explain a process or treatment plan in a language that they were still learning. In situations where students did try to provide an explanation, patients could not always understand them. Most of the time students could not explain procedures due to a lack of the necessary terminology. In these instances, students would use a mixture of English and isiXhosa in order to try and get the information across. Due to a lack of relevant terminology, students also did not feel confident enough to communicate with the isiXhosa speaking patients.

Students mentioned that they had little time to practice speaking isiXhosa, and therefore, even after completing the clinical communication course, the language is still challenging.

Figure 5-3 demonstrates students' perceptions of their ability to accurately convey relevant information and explanations to patients:

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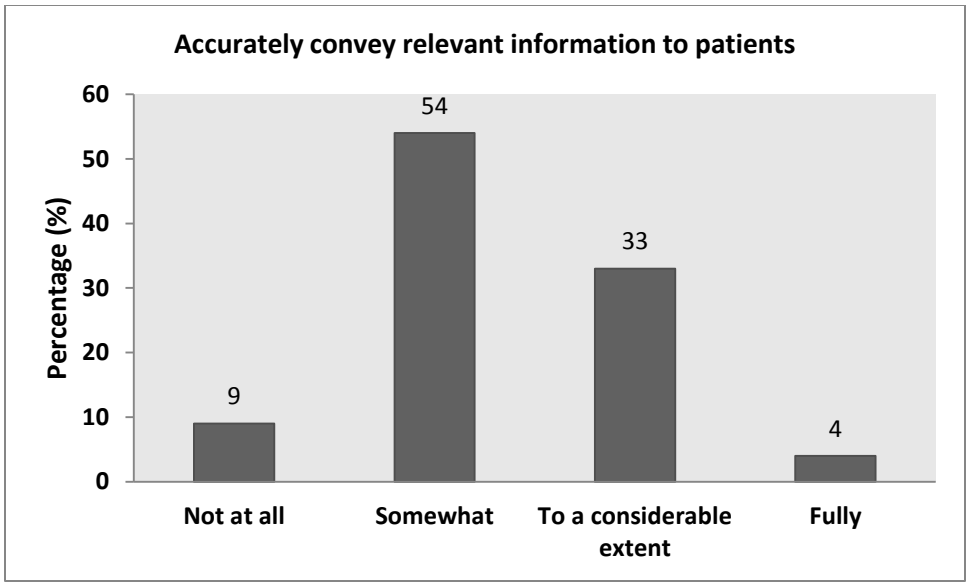

Figure 5-3: Self-perceived competency in conveying relevant information

Sixty-three percent of the respondents believed that they lacked sufficient ability to accurately and efficiently convey relevant information to patients. Only 37% of the respondents were more confident of their ability to do this. Some of the students stated that the basic vocabulary that they had acquired might not be enough, but it did help them to a certain extent. Even the basic vocabulary would be helpful when trying to explain procedures to isiXhosa speaking patients who cannot understand English. One respondent said that *"knowing the language is extremely useful when the patient only speaks isiXhosa"*.

Observations of the simulated patient encounters

One of the competencies contributing to the ability to convey relevant information to patients is the skill to retrieve patient-specific information from the data systems. This aspect was not demonstrated by students as this is not taught in the clinical communication course.

In the observations of simulated patient encounters I did not observe students demonstrating the ability to deliver information to patients in an understandable way. Students were either questioning patients or giving instructions to patients. For example, during Occupational Therapy

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students' consultations about disability grants, they were mostly asking questions about physical abilities, criminal offences, accommodation, lifestyle habits, personal details, etc. On the other hand, Human Nutrition students, for example, mostly gave instructions while performing a clinical and anthropometric examination. There were no instances where students gave any kind of information to the patients involved.

From only questioning patients or providing instructions, it can be inferred that students did not have the ability to encourage discussions and patient participation in decision-making. There were no opportunities where students asked the patients how they felt about a certain problem experienced or whether they would like to come back for a follow-up appointment or rather be referred to someone else for further examination. The only thing that students would do was to provide a follow-up appointment date for the patient. Other than this, there were no discussions between student and patient. Therefore, students lack the ability to effectively convey relevant information to patients.

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

Survey responses

Students found it difficult to develop a common understanding of issues and problems with patients in order to develop a shared plan of care. This was due to them experiencing a lack of sufficient vocabulary, and therefore students *"don't feel comfortable with assisting isiXhosa speaking patients"*. One respondent advanced the view that *"there was limited time to practice the language, and therefore did not acquire the ability to develop a common understanding"*.

Students were of the opinion that they could provide a brief description of issues and problems experienced, but that they would need more knowledge, terminology and practice to be able to plan assessments and treatments. The communication course has not taught them how to develop a common understanding of patients' problems and to develop a shared plan of care. Not having the necessary terminology and knowledge made it difficult when patients' responses were not being understood. Furthermore, it was difficult to try and help patients understand their problem. One of the students commented that *"I don't know how to develop a plan of care in isiXhosa yet*

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and my understanding of issues and problems are still underdeveloped" and *"I feel as though the level of isiXhosa we understand is not good enough"*.

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

The following graph reflects students' responses with regard to developing a common understanding of patients' issues and problems in order to develop a shared plan of care:

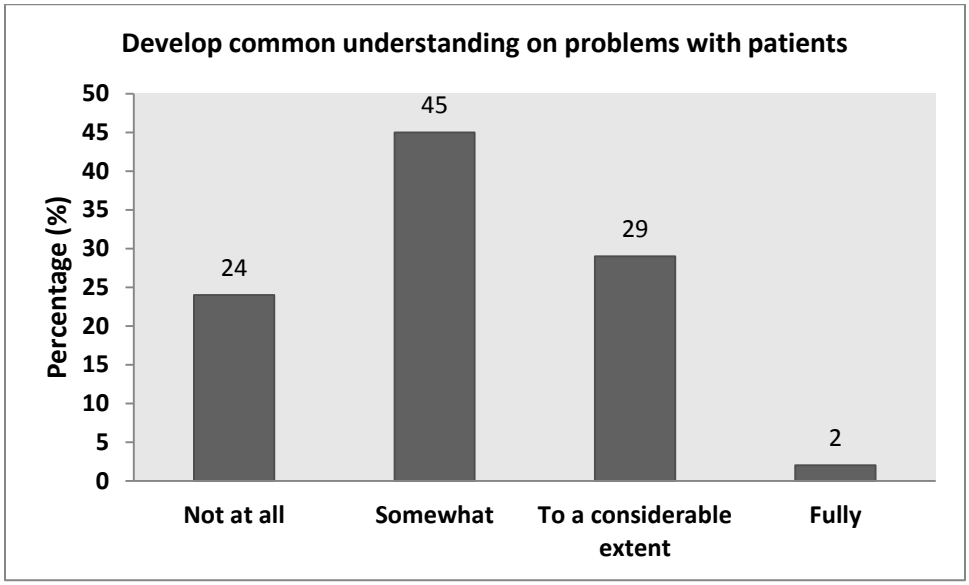

Figure 5-4: Self-perceived competency in developing a common understanding

Sixty-nine percent of the respondents indicated that they could not effectively develop a common understanding on issues, problems and plans with patients to develop a shared plan of care. However, thirty-one percent of the respondents believed that they had the ability to do this. It is thus clear that the majority of students lack the ability to develop a common understanding on problems with patients.

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Observations of the simulated patient encounters

When observing students I found that students could effectively explore problems experienced by patients during their consultations with patients. They had an adequate range of vocabulary which allowed them to ask appropriate questions to their patients. For example, in order for Occupational Therapy students to assess patients' readiness to return to work after having a physical disability, they were able to ask a wide variety of questions regarding pain experienced and patients' physical ability to take care of themselves. Sometimes students struggled to formulate their questions correctly which made the communication process slower, but the core of the questions came across clearly and the patients were able to understand them within the context.

Students were also effective in their approach to explaining a certain process to patients in order to minimize any confusion and misunderstandings. For example, as part of the assessment process during an interview regarding physical disability, Occupational Therapy students could effectively explain to patients how a follow-up procedure would work. They could explain to patients that they would need to make an appointment and return to be assessed for three days in order to determine their work readiness.

However, this was observed to a lesser extent with Human Nutrition and Speech-Language and Hearing Therapy students. Students were more limited in their knowledge. This was also evident from the responses in the questionnaires. Students indicated that they could not explain processes to patients in order to minimize any confusion or misunderstandings. They could only inform patients during the consultation of the procedures that will be followed, for example, indicating that they wanted to measure weight or measure height, or in the case of Speech students informing patients every time they wanted to assess a different aspect (e.g. immediate memory, recent memory and long-term memory) during the neuro-assessment.

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

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

Survey responses

Students reported that they had the ability to make basic clinical notes such as the time and date of an appointment attended. However, students believed that they were not able to explain a diagnosis or convey information about a medical encounter due to limited vocabulary. Students preferred making use of a translator when having to provide written reports as their *"written work (reports) will not be adequate in isiXhosa and it wouldn't feel ethical to do so"*. This is probably due to the fact that the communication course is primarily focused on oral and aural communication skills rather than having to read or write the language.

Students believed that they could provide very basic information orally, but that they would not be able to do anything outside of what has been taught in class due to the fact that *"all vocabulary concerning medical terminology and treatments have not been learnt"*. Students were also concerned about being professional when conveying information. One student commented that even though the basic foundation was there to provide very rudimentary information, they did not feel confident as they *"do not have enough terminology or knowledge to do this professionally"*.

Figure 5-5 illustrates students' beliefs about their ability to convey effective oral and written information about a medical encounter:

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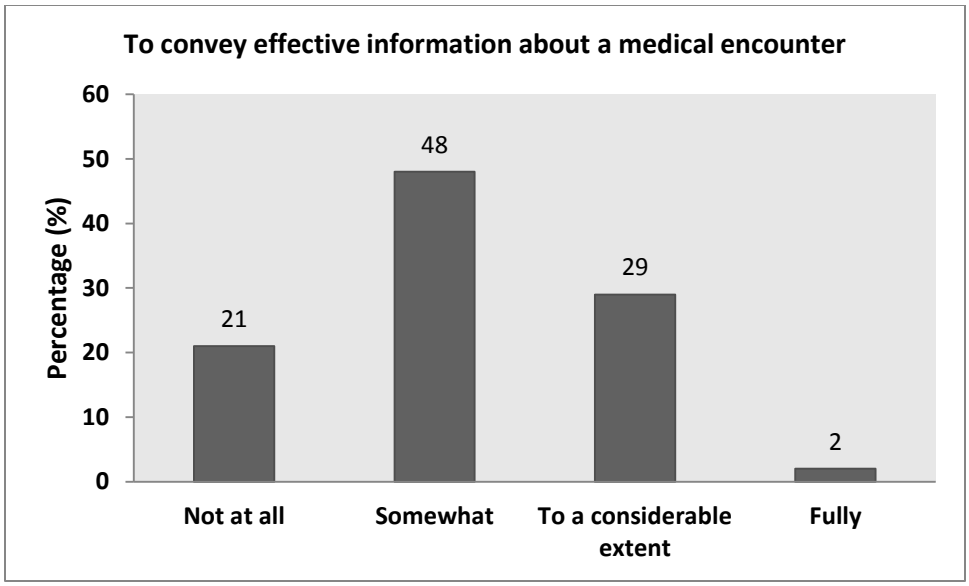

Figure 5-5: Self-perceived competency in conveying information about a medical encounter (orally / written)

To summarise, students believed that they had a very basic set of vocabulary, and even though this was helpful to a limited extent, they could not really effectively convey relevant information to patients orally or in a written form.

Observations of the simulated patient encounters

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

5.5.6 Summary of the findings from the survey and observations

Even though students had not acquired all the vocabulary and knowledge needed to communicate in a clinical context, they still felt confident to apply what they have learnt. One of the students mentioned that she had to assist a first year fellow student in Physiotherapy, and she realized that

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she knew so much more than the Physiotherapy student as the Physiotherapy students do not receive this course. It was clear that students were positive about the isiXhosa clinical communication course. One of the reasons was that *"it is most definitely effective and user friendly"*. Students also believed that it is very appropriate to learn another language.

Apart from the course being effective in providing students with some basic knowledge and terminology, students still held the opinion that learning the language was a challenge and that using the language sometimes came across as being *"rehearsed"* as students tended to rely a lot on the manual. This had the effect that students would not be able to understand patients if their responses were different to what had been learnt.

The following table (Table 5-2) summarises students' ability to demonstrate the respective requirements of the communicator competency:

Table 5-4: Summary of demonstrating the core competencies of the respective communicator competencies

Competency 1 - Develop rapport, trust and ethical relationship with patients	
Core competencies	**Comments**
Demonstrate a patient-centred approach in interactions with patients	This was partially demonstrated. Some students appeared very distant towards their patients. Students tended to be very professional instead of showing more interest and warmth towards patients. It almost seemed as if students just wanted to get the consultation over and done with without really paying personal attention to their patients.
Demonstrate flexibility in the application of communication skills	Students did not always know how to cope when breakdowns in communication occur. Some students used non-verbal actions (gestures), while others used key words / phrases; these strategies, however, were not always successful.
Establish positive relationship with patients in terms of trust, respect, honesty and empathy	Students were socially appropriate by addressing the patient in a proper manner, shaking their hands, introducing themselves and their student role well, asking permission to ask questions, and ensuring the patient that information will be confidential. If patients indicated that they were not feeling well students showed empathy towards the patient.

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Competency 2 - Accurately elicit relevant information from patients	
Core competencies	**Comments**
Gather relevant information about health problem experienced	Students were restricted in gathering relevant information due to lack of vocabulary and content knowledge. In context, students could gather information to a certain extent by asking relevant questions.
Effectively clarifying uncertainties by probing sensitively	Students were not always able to clarify uncertainties due to lack of vocabulary.
Competency 3 - Convey relevant information and explanations accurately to patients	
Core competencies	**Comments**
Retrieve patient-specific information from data system	This aspect was not facilitated by the course.
Deliver information to patient in an understandable way	In context and with the acquired vocabulary, students could deliver information, even though grammar and pronunciation may not always have been correct.
Encourage discussions and participation in decision-making	Students lacked sufficient vocabulary and background knowledge of patients to involve them in decision-making.
Competency 4 - Develop common understanding of problems and plans with patients	
Core competencies	**Comments**
Identify and explore health problems experienced by patients	In context, students could explore health problems by asking relevant questions.
Respect diversity (gender, culture, religion) in decision-making	Due to the fact that students could not engage in a decision-making process, this aspect could not be demonstrated.
Effectively communicate in difficult situations with patients to minimise confusion and misunderstandings	Within context, clear explanations could be provided to avoid confusion. For example, OT students could explain the assessment process of a disability grant. However, Human Nutrition and Speech students did not demonstrate this aspect.

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Engage patients in shared decision-making regarding a plan of care	Students did not have the necessary vocabulary to do this effectively.
Competency 5 - To convey effective oral and written information about a medical encounter	
Core competencies	**Comments**
To convey effective oral and written information about a medical encounter	This aspect was not facilitated by the communication course. Students lacked the necessary knowledge in this regard. Students were limited to only being able to provide the patient with a follow-up appointment date. However, effective information could not be conveyed.
Present effective oral and written reports of clinical encounters	Students did not demonstrate this as this aspect was not facilitated by the communication course. Students did not have the requisite knowledge in this regard. Students can indicate when a consultation occurred, as well as the health problem experienced by patients, but detailed information cannot be provided.

From the abovementioned responses and observations it is evident that students had not acquired sufficient vocabulary enabling them to effectively communicate with patients. Students were limited to only using basic vocabulary in their consultations with patients. In terms of eliciting information, conveying information, developing a shared plan of care, and conveying oral and written information about a medical encounter, students were not very effective. However, with their basic vocabulary and knowledge of the language, students were able to form positive relationships with patients whom they encountered. It can thus be concluded that students were effective in developing rapport with patients (See section 5.5.1 and Chapter 3, section 3.3).

The responses gained from interviews with the lecturers of the isiXhosa clinical communication course will now be discussed.

5.6 Interviews with lecturers

The two lecturers of the isiXhosa clinical communication course were interviewed individually. The interviews were recorded after which they were transcribed. These lecturers are lecturing Human Nutrition second and third years, Occupational Therapy second and third years, and Speech-Language and Hearing Therapy second, third and fourth years. Four questions were posed,

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namely 1) How would you describe the students' attitudes towards the isiXhosa communication course? 2) How are you attempting to meet the requirements of the communicator competency of the CanMEDS framework through your teaching of the isiXhosa communication course? 3) To what extent is the isiXhosa communication course effective in capacitating students to meet these requirements? 4) How do you think the isiXhosa communication course could be changed to be more effective in this regard?

5.6.1 Responses of the lecturers

a) Attitudes

Based on student feedback, lecturers believed that students viewed the communication course in a very positive light. They motivated this by pointing out that students experienced the language component as adding value to their clinical content, i.e. the content that students need for consultations with patients, as stated by one of the lecturers: *"I think, generally, looking at student feedback and chatting to them occasionally, they view the communication courses as very positive. They also see it as adding to the content of the courses in the clinical situation".* The lecturers therefore believed that the course empowered students in the clinical situation, that students enjoyed the course and that they saw the value it added to their development. This was confirmed by a lecturer who said that *"they feel it empowers them, especially in the clinical situation and I think they enjoy the courses".* However, sometimes students only realized the value of the course after they had completed and not at the time of doing the course, as a lecturer mentioned: *"I also think that sometimes they only realize it after they have done the courses and not at the time".*

The isiXhosa communication course is a compulsory course, and in lecturers' experience students are not very pleased or excited about it once they are informed about this. Lecturers reported that students initially showed no interest at all in the course and were more concerned about the reasons why they had to do the communication course. However, once they started experiencing success and seeing how well they perform, their attitudes changed and they became more positive. When students realized the value, the need and the practical application thereof in clinical work, they started appreciating the course much more and, in turn, put more effort into learning the language. One lecturer explained as follows:

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"Because it's compulsory for students to do, when they are informed, at that point they are not too pleased with it, they are not interested, they ask all sorts of questions as to why they have to do it, but once they get involved and once they start seeing how well they do, they really take it very very well, and they appreciate it, and they put effort in".

b) Teaching methods to meet requirements of the communicator competency

The lecturers believed that they were attempting to meet the requirements of the communicator competency through their teaching by trying to provide students with as much exposure to the language as possible. Lecturers explained that students were doing a lot of communicative activities, such as role-plays in class with peers. These role-plays reflected a variety of patient encounters, i.e. every student would represent a different kind of patient which enabled students to be exposed to different backgrounds and different situations. Lecturers further explained that, when students did assessments, they did them with isiXhosa speaking people who acted as simulated patients. Even though simulated patients are trained, there was still some flexibility, because the simulated patients remained who they were as persons. In this way, students were exposed to different people who represented different situations every time. Lecturers confirmed that students were required to take different histories, to elicit different kinds of information, and to convey a variety of information depending on the type of patient engaged with. A lecturer explained it as follows:

"The course is structured as such that they get enough exposure. Initially, their first oral, they do it with peers, so that's already exposing a student to another, and that means exposing them to their background and, you know, all the varieties in terms of the information that they need to get of them. And then secondly, we work with the whole class where students exchange pairs every time, and you know, each time you get to work with a different student that represents a different caliber of a patient. Finally, when they do their exams, they do it with total strangers who are simulated patients. So even though simulated patients are trained, there is a little bit of flexibility because they remain who they are. So, that is where they get to be exposed to different people every time. So when it comes to eliciting information like the patient's history, every time it's different, every time they engage with a different person."

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Lecturers recognized the importance of knowing and understanding all the requirements of the communicator competency in order for effective teaching to occur. This was confirmed when a lecturer said that *"I think first of all you should know all those requirements and then you should try to develop your courses to actually integrate those competencies"*. For this reason, they were constantly attempting to do research and attend workshops which would enable them to apply effective teaching strategies in order to meet the requirements of the communicator competency through their teaching. Furthermore, the lecturers reported that they received feedback from students at least once a year to determine whether their teaching strategies were successful or not, and where they could possibly change or adapt.

The lecturers indicated that they supported one another by sharing their knowledge regarding the communicator competency in order for all lecturers to understand the necessary requirements so that they were able to share this knowledge with students as well. One of the lecturers put it as such:

"I should also share with my colleagues so that we are all on the same page, because it is senseless if one group understands and knows how to do it and the others don't. So first of all, equip yourself with the relevant skills to be able to engage with students so that they can get the competencies."

c) Effectiveness of communication course

Lecturers explained that during the oral examinations, *"we check students' oral communication skills at the end of the course to see how they interact with the patients"*. In this way the lecturers could determine 1) whether students understood what they learned, 2) whether students did not understand and thus rote learned, and 3) the way in which they engaged with patients by looking at verbal and non-verbal cues, and how sensitive students were towards cultural differences.

The lecturers believed that this evaluation process, as well as student feedback had proved the isiXhosa communication course to be effective to the extent that it did capacitate students in meeting the requirements of the communicator competency, especially due to the fact that students were exposed to different possibilities and options. A lecturer confirmed this by saying that *"this is really the test when you can see whether it's been effective or not"*.

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However, lecturers reported that they were concerned about whether the students really used the language. Lecturers believed that in the clinical context, the course was effective in providing students with the necessary knowledge and vocabulary. A lecturer confirmed this by saying that *"the programme itself is quite effective and when it comes to clinical context the programme is quite efficient"*. However, students were not obliged to use the language and nothing required them to do so, and thus it became a matter of choice. Therefore, if students chose not to use the language, the training would have been in vain. A lecturer expressed her concern when she said that *"the only part that I would be concerned about is where the students do really use it, because they are not obliged, there isn't anything requiring them to use it, it's a matter of choice"*.

d) Suggestions for change in the communication course

As far as the Faculty is concerned, the lecturers believed that this communication course did *"not have the 'buy-in' from all the disciplines"*. Other departments or disciplines did not always understand the importance of the development of the student as a whole in terms of the graduate attributes, and more specifically the communicator competency. This was confirmed by a lecturer who said that *"departments and disciplines can understand the importance in terms of the whole development of the student in terms of the graduate attributes where the communication is one of the attributes"*. Lecturers were thus of the opinion that staff of the isiXhosa communication course should work more closely with the other departments in the Faculty for them to realize the importance of developing students' communication skills.

Lecturers suggested that this course should be revised so that it could become a fully integrated or embedded course or module, instead of regarding the language component as a separate entity. One of the lecturers mentioned that *"We must look at how can it become a fully integrated or embedded programme; we must look at what extra we can do"*. However, they confirmed that the logistics around the course in terms of time was the biggest challenge (*"the time table is always the biggest problem; the logistics where we do not have enough time"*). Lecturers further indicated that it would be beneficial if the language component could be integrated to be part of students' clinical rounds. By including it in the clinical rounds, it should then be compulsory that students speak isiXhosa when they come across an isiXhosa speaking patient, as indicated by a lecturer *"I*

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think where it is compulsory for them to speak isiXhosa when they do come across an isiXhosa speaking patient". Should it become compulsory in the clinical rounds, an assessment should be included which would contribute towards students' marks in order for students to take it more seriously. This was suggested by a lecturer who said that *"maybe also implement an assessment that has to be done there where it is compulsory and where it also contributes towards their marks"*. In addition, requiring students to use the language in their clinical rounds would result in the language actually being applied in real practice instead of in a simulated situation. One of the lecturers said that *"it would have a realistic outcome"*.

As far as content was concerned lecturers were of the opinion that *"there would always be opportunity for growth"*. They explained that students came across a wide variety of patients and a lot of these situations were not included in the course material. Besides being able to use the language in the immediate clinical context, it would also be valuable for students to acquire general knowledge and vocabulary that could be used in other contexts. A lecturer explained that *"besides their immediate context, the clinical context, I think a little bit of information or content outside of that could also be introduced so that they could also interact with their patients outside the context so that they are not limited to what the consultation is about"*. This would allow students to use the language more broadly than the consultation and build students' confidence.

5.7 Discussion

For the purpose of this section, the data obtained from the document analysis of the course material, the questionnaires, the observations of consultations, and the interviews with lecturers are interpreted and discussed.

5.7.1 IsiXhosa course and teaching strategies

To bridge the cultural and language divides between patients and students, the course material was developed with the aim of developing students' clinical communication skills. Generally, the isiXhosa communication course contributed towards developing the respective requirements of the communicator competency (refer to Chapter 3, section 3.2 for communicator requirements). Even though the course only provided students with basic knowledge and vocabulary, students were still able to apply their acquired knowledge and skills to some extent in the clinical context.

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According to Iona (2014), when focusing on language acquisition, it is important to bear in mind the relationship between students' epistemological beliefs, their choice of learning strategies, and the learning outcomes in terms of language acquisition and communication skills (Chapter 2, section 2.2.1). More importantly, the success of language programmes depends on internal factors such as the cognitive and affective dispositions of students (Iona, 2014). Stevick (1980) advances the view that the acquisition of language and communication skills is more dependent on internal processes rather than on teaching materials and teaching methods (Chapter 2, section 2.2.1). However, with appropriate teaching, effective communication skills, including language, can be acquired and retained (Spencer & Silverman, 2001) (Chapter 2, section 2.4.1).

In attempting to meet the requirements of the communicator competency, teaching strategies were applied to provide students with as much exposure as possible to communicative activities during the course (section 5.6.1). According to Johnson and Johnson (2000), role-plays are important for learning and mastering new skills. Role-play, as well as the use of simulated patients is often used in health professions education to practise clinical communication skills by providing a bridge between theory and practice (Stoneham & Feltham, 2009; Kurtz *et al*, 2005) (Chapter 2, section 2.2.2). Students were provided with opportunities in the isiXhosa communication course where they could engage in a variety of role-plays with trained simulated patients. During these role-plays the treatment, developing rapport, eliciting of information, or taking the patient's history was different every time, allowing students to be exposed to different types of patients.

Even though lecturers were attempting to meet the requirements of the communicator competency through their teaching, they were limited to the content that the course material provided (section 5.4.1). They were not teaching content outside the course material (Table 5-1). Therefore, students would not be competent in meeting the requirements of the communicator competency if the course material is not aligned with the respective requirements.

5.7.2 Competency level of requirements of communicator competency

From the interviews it was evident that lecturers believed that the isiXhosa course met the requirements of the communicator competency; however, student responses and observations proved differently. From student responses and observations, it was clear that students felt most confident in developing rapport, trust and ethical relationships with patients. Students made eye-

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contact, exchanged greetings, introduced their student-roles, and enquired about the patient's/client's problem (Bakic-Maric & Bakic, 2008) (Chapter 3, section 3.3). The course material included content regarding 1) developing rapport by exchanging greetings, doing introductions, and bidding farewell, and 2) developing a case history. Furthermore, students were introduced to the cultural aspect of the language, i.e. cultural values relevant to patients, family and the community. Students were specifically introduced to ways of showing respect and being polite, understanding relationships, and understanding the impact of differences of culture and language between groups. Therefore, students understood the cultural differences between themselves and patients, and could thus establish positive relationships by demonstrating socially appropriate behavior (section 5.4.1). This is an important aspect, because communication is much more than merely disposing of vocabulary and correctly applying language structures. It is about understanding cultural differences, and building relationships and trust by using appropriate communication skills (Epstein, 2005) (Chapter 3, section 3.2).

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

Students' competency levels in the above-mentioned, i.e. eliciting relevant information of patients, conveying relevant information and explanations, and developing a common understanding of problems experienced can thus be improved. Having only basic vocabulary can become problematic. Basic vocabulary limits students' ability to give information about a diagnosis and expand on it, or to explain a process or treatment plan in a language that they are still learning. Students were mostly taught how to ask relevant questions, rather than how to provide patients with the necessary information and explanations, and thus students could not communicate important information to patients. Apart from not being able to provide information to patients, students could also not develop a common understanding of issues and problems with patients in order to devise a shared plan of care. They found this difficult due to experiencing a lack of appropriate vocabulary. The inability to formulate a diagnosis, deliver information, create mutual understanding, and facilitate a shared plan of care, will lead to poor patient-centered

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communication. Poor communication can lead to undesired outcomes, as effective communication is critical for optimal patient outcomes (Frank, 2005) (Chapter 3, section 3.2).

Students lacked the ability to convey effective oral and written information about a medical encounter due to insufficient vocabulary. Seeing that the communication course was primarily focused on communication skills, the course material only included activities which developed the basic reading and writing skills of students. These activities included basic translations or formulating of sentences, and therefore students were not competent in reading or writing the language. Thus, if students had to produce written reports, they would need a translator as their written isiXhosa was inadequate. The use of interpreters or translators could influence the success of communication, and consequently the quality of health care (Penn, 2007) (Chapter 3, section 3.4).

5.7.3 Demonstrating patient-centredness

Students partially demonstrated the ability of being patient-centered in their interactions with patients. Patient-centeredness must be enabled through shared decision-making and effective dynamic interactions with patients (Frank, 2005). This is essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care (Frank, 2005). Even though students were able to develop rapport with patients, they were unable to provide sufficient information when formulating a diagnosis, and thus a shared plan of care could not be facilitated. A further component of demonstrating a patient-centered approach is the ability to actively listen while the patient explains his / her concerns and then summarizing what the patient has said (Boyle, Dwinnell & Platt, 2005). During observations there were no instances of patients explaining their concerns, followed by students summarizing the concerns before starting the questioning process. This led to poor communication during consultation (Chapter 3, section 3.3).

Furthermore, during the observations of students with simulated patients, it seemed as if students did not want to become emotionally involved with patients by showing empathy. In a patient-centered approach it is important to show empathy. According to Jani, Blane and Mercer (2012) empathy plays an important role due to the fact that it enhances patient satisfaction, enablement, as well as the improvement in health outcomes (see Chapter 3, section 3.3).

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5.7.4 Communication limitations

Even though students were mainly taught how to ask relevant questions, they still sometimes struggled to formulate their questions correctly. This made the communication process slower, but the core of the questions still came across clearly and the patients were able to understand students within the context. Pfaff and Couper (2009) advance the view that second language learning has moved away from the traditional focus on grammar and translation to communicative and task-based methods. The natural approach of Krashen (1983) complements the view of Pfaff and Couper and suggests that language is acquired by hearing the language, and not by learning its formal grammatical rules (Chapter 3, section 3.5). The course material did include the necessary linguistic structures to enable students to formulate questions and make themselves understood, and these linguistic structures were reinforced through interactive and task-based learning activities. However, it seemed as if students were too focused on getting the grammar and pronunciation right, rather than focusing on speaking the language in an intelligible manner. When students conversed with patients, it seemed as if what was being said was merely 'parrot speak'. Once students couldn't remember what to ask or say next, the consultation could not proceed. This points to the challenges of using a second or third language to communicate in the healthcare context. Even though many healthcare professionals would like to be able to speak the language of their patients, there is little expertise on effective ways of successfully acquiring a second language in the health care context (Schlemmer & Mash, 2006).

Students were very dependent on what they had learnt in class. In every consultation, patients responded differently, and this variety of responses was not covered in the course. This resulted in students being limited to certain contexts. It was clear from the layout of the course material (section 5.4.1) that students were only expected to be proficient in certain contexts. Students were thus restricted in terms of content and knowledge, and thus also vocabulary. Therefore, if patients responded differently to what had been taught in class, students were unable to understand them. When students did not understand, they were not always able to clarify what had been said and, in turn, a breakdown in communication between student and patient occurred. Due to the fact that students did not learn the skill of strategic competence, they did not know how to enhance the effectiveness of communication or to repair and compensate for breakdowns in communication (Meenakshi, 2015). In such instances, students would use a mixture of English and isiXhosa in an

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attempt to get the information across clearly. Some students only relied on the key words to get their message across. Sometimes, even though not always successful, students would try to cope in these situations by making use of either pictures or gestures. For example, there was one instance during an observation when a student forgot how to say 'sit down', and as coping mechanism, the student showed the patient by means of hand gestures to sit down.

There were instances during consultations when students pronounced words incorrectly, as well as used incorrect grammatical structures. However, in context, the patient could guess what the student was trying to explain. The fact that students were observed in simulation and that simulated patients (who were trained) were used, could influence the communication process. If students were to be observed within actual practice, patients might not have understood them. Using incorrect pronunciation and grammar could be due to the fact that the isiXhosa communication course is mainly communicatively orientated. There is an assumption that a pure communicative approach to language learning produces speakers who make many errors which could have been corrected with the knowledge of grammar (Hammerly, 1991) (Chapter 3, section 3.5). Language learning is seen as a noble goal, but it is a goal which is not easy to achieve in a busy working practice of health care (Pfaff & Couper, 2009).

Students also experienced that their isiXhosa speaking patients tended to speak fast and they pronounced words differently to how students had been taught. This further made the process of understanding the patients' responses difficult. When students did not understand patients' responses, they identified familiar words and then tried to construe meaning in context. Willis (2004) argues that beginner additional language learners learn more easily in a natural or real life environment, and learners should take note of useful words and start putting together words and phrases in order to understand, as well as to convey messages.

5.7.5 Communicating in clinical context

Even though students were not fully competent in the language, having some communicative competency in isiXhosa made them feel more confident when confronted with isiXhosa speaking patients. By trying to communicate in the patients' language students won the trust of the patients, and thus patients would cooperate more readily in trying to help students understand them. It is useful for students to immerse themselves in the community where the target language is spoken,

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or to have a tutor. The skill of listening in learning a language is very important. By listening, vocabulary and understanding of implied meaning are expanded, and so, effectively learning a language depends, amongst other things, on how much one listens and integrates what has been learnt. It is one thing to learn a new language, but it is another to actually apply what has been learnt in practice. The ideal is to be prepared to practice speaking with patients confidently (Pfaff & Couper, 2009) (Chapter 3, section 3.5).

Regardless of the challenges students faced, they remained positive towards the isiXhosa clinical communication course. Once students were in the clinical context, they started realising the practical use of the communication course and the value it added when in consultation with isiXhosa speaking patients. However, if students had a choice, they would rather not approach an isiXhosa speaking patient due to a lack of confidence in their communication abilities.

5.7.6 Challenges

After completing the isiXhosa clinical communication course, students still found it challenging to speak the language. Apart from the course being restricted in terms of vocabulary, students did not have enough time to practice and use the language. To help students overcome this challenge, it would be beneficial to integrate the course into students' clinical rounds, rather than treating it as a separate entity. This would lead to more realistic outcomes by applying the language in real practice instead of it being used in a simulated situation, exposing students to more realistic scenarios with patients. Communication skills training is often done in isolation, and not as part of the context in which it needs to be applied (Silverman, 2009). There is thus a strong argument for providing a clinical learning environment which is suitable for communication skills training. Not only is it necessary to create a clinical learning environment, but also, more specifically, focusing on discipline-specific communication skills training (Conn *et al*, 2012) (Chapter 3, section 3.4). However, the various departments involved first need to understand the development of the student as a whole in terms of the graduate attributes, and more specifically the communicator competency, in order for the communication course to be accepted as an integral and vital part of the training of allied health science practitioners.

Besides exposing students to clinical content (section 5.2) it would also be beneficial to expose students to general content used in normal everyday conversations. This would allow students not

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to be limited to what the consultation is about, and help them have a better understanding of patient responses which will build students' confidence.

Some students had, at the time of the data collection, not yet encountered an isiXhosa speaking patient. However, even they were confident that they would be able to apply their basic knowledge during a consultation with an isiXhosa speaking patient. Students thus believed in their capability to communicate with patients and therefore had a high level of self-efficacy (see Chapter 3, section 3.5). Having a high level of self-efficacy means that, if students encounter an isiXhosa speaking patient, they would (with their basic vocabulary and knowledge) be able to persist, even in difficult situations (Artino, 2012).

5.8 Conclusion

From the results obtained it is clear that the isiXhosa communication course has provided students with basic knowledge and vocabulary in a clinical context. Even though students have not acquired all the vocabulary and knowledge needed to communicate in a clinical context, they were still able to apply what they had learnt.

The course material provided to students is not fully aligned with the requirements of the communicator competency. Students are competent in developing rapport, trust and ethical relationships with patients. They find it more difficult, however, to elicit relevant information from patients, to convey relevant information and explanations, and to develop a common understanding on problems experienced. The communication course does not equip students to meet the requirements of retrieving patient-specific information from the data systems. Lastly, students lacked the ability to convey effective oral and written information about a medical encounter due to insufficient vocabulary.

In the following chapter, conclusions of the study are drawn and recommendations are made.

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6 CONCLUDING OBSERVATIONS

6.1 Introduction

Communication in the health care context is important. Without functional communication skills, healthcare professionals are unable to sufficiently assist patients/clients. More specifically, if healthcare professionals cannot speak the language of their patients/clients, they are unable to counsel patients/clients, and safe, high-quality care cannot be delivered. To enable healthcare professionals to learn the language of their patients/clients, effective communication courses need to be developed and implemented. Learning the language of patients/clients is thus an expectation of healthcare professionals' profession, and therefore language learning needs to be part of the training of healthcare professionals.

In South African institutions of higher education, there are few effective language programmes that equip student-professionals with communication skills in the context of their profession (Maseko, 2007b). Therefore, as a result, student graduates find it difficult to cope in a multilingual/professional clinical environment (Maseko & Kaschula, 2009). The Faculty of Medicine and Health Sciences (FMHS) at Stellenbosch University has developed and implemented a clinical communication course which are specific to the needs of each of the respective allied health professions undergraduate programmes.

The aim of this study was to evaluate the isiXhosa clinical communication course as presented in the Division of Speech-Language and Hearing Therapy, the Division of Occupational Therapy, and the Division of Human Nutrition in order to determine whether it effectively contributes to the development of the communicator competency of the CanMEDS framework. Furthermore the aim was also to explore students' experiences of the isiXhosa communicative course implemented at FMHS, Lastly, the aim was to investigate students' communicative competence after completion of this clinical communication course.

The research question was specifically formulated as: *To what extent does the isiXhosa clinical communication course in the Faculty of Medicine and Health Sciences at Stellenbosch University satisfy the communicator competency requirements of the modified CanMEDS framework?*

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This research project included allied health professions students who were in their final year of participating in the isiXhosa clinical communication programme. These students were specifically third-year Human Nutrition Students, third-year Occupational Therapy students, and fourth-year Speech-Language and Hearing Therapy students. Students in the final year of the communication course were specifically chosen as they would have considerable experience of the course. Apart from students, lecturers who are involved in teaching the course were included in the study as well. Data were collected by means of a thorough document analysis of the programme material, observations of students during consultations with simulated patients, a survey of students and interviews with the concerned lecturers. The following sub-questions were investigated in order to answer the central research question:

Sub-question 1: To what extent does the documentation of the current isiXhosa communication course provide evidence of meeting the requirements of the modified CanMEDS communicator competency?

Sub-question 2: What are students' perceptions of the extent to which the isiXhosa clinical communication course equips them to meet the requirements of the CanMEDS communicator competency?

Sub-question 3: To what extent are lecturers of the isiXhosa clinical communication course attempting to meet the requirements of the modified CanMEDS communicator competency?

Sub-question 4: To what extent do observations of clinical consultations of students in the course provide evidence of meeting the requirements of the modified CanMEDS communicator competency?

Sub-question one was answered by means of a thorough document analysis of the module objectives and outcomes, as well as the course outlines. This academic course content was checked against the respective requirements of the communicator competency of the CanMEDS framework. Sub-question two was answered through the analysis of students' survey responses, while sub-question three was answered through the analysis of interviews with the concerned staff. Lastly, sub-question four was answered by observing some of the Occupational Therapy students, the Human Nutrition students, and the Speech-Language and Hearing Therapy students in a simulated clinical setting.

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In Chapter 5, the data obtained from the document analysis, questionnaires, observations, and interviews were analysed and interpreted. By making use of document analysis, questionnaires, observations, and interviews the data could be triangulated. The data obtained from the observations, interviews and the document analyses were compared with the requirements of the communicator competency of the modified CanMEDS framework, and the responses obtained from the questionnaires were analysed according to the extent to which the isiXhosa clinical communication course contributed to developing the respective communicator competencies (see Chapter 4, section 4.9). The results were discussed (Chapter 5, section 5.7), and based on this discussion, a number of conclusions may be drawn.

6.2 Conclusions

Firstly, it is evident that the teaching approach in the isiXhosa clinical communication course has moved away from traditional teaching of grammatical structures and translation methods (Pfaff & Couper, 2009) (refer to Chapter 3, section 3.5). This course does include linguistic structures which allow students to make themselves understood; however, the course is mainly designed to be communicative, adopting a task-based approach with various task-based activities. The classroom setting is communicatively-based where students have the opportunity to engage in 'real life' situations (refer to Chapter 5, section 5.2). Therefore, instead of producing healthcare professionals who are only competent in grammar, but unable to communicate with patients (Pfaff & Couper, 2009) students involved in these courses are able to communicate with patients, even if it is only to a limited extent (Chapter 5, section 5.7).

Due to the fact that it is important that students have sufficient opportunities to practice their newly acquired skills and knowledge in a variety of environments (Conn *et al*, 2012), simulation is integrated in the communication course. Students are provided with opportunities to engage with simulated patients who are trained according to a variety of contexts. This creates a powerful learning experience for students in a controlled learning environment (Kalaniti & Campbell, 2015). The theory of Kolb (1986), i.e. experiential learning, (see Chapter 2) supports learning in simulation, as it emphasises the concept of 'learning by doing' with learning as a process of building on concrete experiences.

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Secondly, I concluded that in spite of an explicit focus on learning how to communicate in a clinical context, students tend to focus on getting grammar and pronunciation correct, rather than trying to communicate intelligibly (Chapter 5, section 5.7.4). Furthermore, students tend to memorise the content taught in class, instead of understanding the language. This could be due to the fact that students might not regard the language component as important, and thus just memorise in order to pass. Also, the workload of students is heavy which causes students not to have enough time to devote to learning a new language. Literature confirms that students favour different types of learning, also when learning a new language. Some students favour memorisation and other students regard grammar as an important aspect of language learning (Ioana, 2014). However, simply memorizing and only regarding grammar as important can become problematic. The results from this study highlight that those students who memorized the content, were unable to continue with the consultation if they forgot what to ask or what to say next, and as a result communication broke down, and language barriers occurred between students and patients. To ensure quality healthcare, there must be a flow of communication between patient and health care professional (Spencer & Silverman, 2001).

Thirdly, students are dependent on the content (refer to Chapter 5, section 5.2) in the manuals and what they have learnt in class (see Chapter 5, section 5.7.4). When patients respond differently to what has been learnt, students are unable to understand them. Furthermore, the content in the manuals is restricted, as not all the health problems that students encounter are covered in the manual. Students are mostly taught how to formulate and ask questions in an attempt to gather information. Language is essential to the role of the communicator of the CanMEDS framework as described by the respective key competencies (Chapter 3). The fact that the course material is restricted in terms of content results in it not being aligned with the requirements of the communicator competency. Students are competent in developing rapport, trust and ethical relationships with patients. However, they find it difficult to elicit relevant information from patients, to convey relevant information and explanations, and to develop a common understanding on problems experienced. Furthermore, students lack the ability to convey effective oral and written information about a medical encounter due to insufficient vocabulary. For students to be able to provide patients with information and explanations or to provide information regarding medical encounters, knowledge of these medical encounters and sufficient vocabulary are needed. To gain the necessary knowledge of the medical encounters and vocabulary, relevant content is

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important. The requirements of the communicator competency can only be achieved once students have acquired the necessary content knowledge which would enable them to meet these requirements.

Fourthly, as is evident from literature (refer to Chapter 3, section 3.2), communication comprises more than merely vocabulary and language structures. It is about understanding cultural differences and building relationships by using appropriate communication skills. It is also about understanding a person as a whole, and thus focusing on the importance of patient-centeredness, and, in turn, patient-centered communication (Frank, 2005). Even though students are aware of the cultural differences between different language groups, they still lack patient-centeredness (Chapter 5, section 5.7.3). Students are well trained in developing rapport and trust, but they lack knowledge in formulating a diagnosis, delivering information, reaching mutual understanding, and facilitating a shared plan of care. These aspects are important as patient-centered communication must be enabled through shared decision making and effective dynamic interactions with patients (Frank, 2005).

Lastly, literature makes a strong argument for having a clinical learning environment which is suitable for communication skills training (Conn *et al*, 2012) (Chapter 3, section 3.4). Yet, communication skills training is often done in isolation, and not as part of the context in which it needs to be applied (Silverman, 2009). Not only is it necessary to create a clinical learning environment, but also, more specifically, focusing on discipline-specific communication skills training (Conn *et al*, 2012). The isiXhosa clinical communication course are designed to be discipline-specific, i.e. the content is specific to each of the respective undergraduate programmes involved (see Chapter 3 & Chapter 5). However, this course are taught in isolation, and not as part of a clinical / practical module (Chapter 5, section 5.7.6). I would argue that the course will benefit students more in terms of exposure to the language and vocabulary if they could be integrated to be applied in a 'real life' context, rather than in simulation. Students do learn better if the acquisition of skills takes place within the context in which those skills are to be applied (Woolley & Jarvis, 2007).

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6.3 Implications

The findings and conclusions of this study may have implications related to the isiXhosa clinical communication course, as well as future research into the learning of isiXhosa in the health care context.

6.3.1 Implications related to the isiXhosa clinical communication course

Firstly, the findings of this study point to the fact that teaching the isiXhosa clinical communication course as a separate entity is not effective. There is a need for the course to be integrated to be part of a clinical or practical module in order for students to apply their communication skills and knowledge in 'real life' contexts, instead of in simulation. In this way, students will be exposed to a wider variety of patients and health problems and, in turn, their vocabulary will be expanded. This will help students to not only be restricted to what has been learnt from the course material or in class, and will enable them to understand patients, irrespective of whether patients respond differently to what has been taught in class or not. Furthermore, it will motivate students towards trying to understand the language, rather than focusing on grammar and memorizing what has been taught. However, a basic knowledge of the language should still be taught elsewhere before integrating it with a clinical or practical module. This remains challenging as the curriculum of health sciences students is very full which leaves limited time and space for incorporating additional courses.

Secondly, the communication course may need to be revised in terms of content. The content provided to students is not adequate to equip them with the necessary knowledge and skills in order for them to effectively meet the requirements of the communicator competency of the CanMEDS framework. The content mostly allows students to develop rapport, ask questions related to case history, and ask questions regarding health problems experienced by patients/clients (refer to discussion in Chapter 5, section 5.7, as well as the results in Chapter 5, sections 5.5.2, 5.5.3, 5.5.4, 5.5.5). I would suggest that content be included which will expose students to a wider variety of health related issues experienced in clinical context. I would further suggest that content be included which will allow students to provide detailed information about a particular diagnosis, to develop a common understanding on problems experienced by patients/clients, to explain a diagnosis or give information about a medical encounter, and to plan relevant assessments or

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treatments. Furthermore, it would also be beneficial to foreground the requirements of the communicator competency of the CanMEDS framework for the purpose of second language learning by students in these disciplines. This will lead to the lecturers involved developing a deeper understanding of what the role of the communicator competency and its respective requirements entail, and how those requirements could be met in order to be able to align the content with the requirements of the communicator competency. If lecturers know what the requirements of the communicator competency are, they would be better guided in terms of what content to include. In this way, students would be better equipped in terms of vocabulary and knowledge, and would thus better be able to communicate with patients/clients.

Thirdly, the communication course may need to be revised in terms of the duration of the course (refer to Chapter 5, Table 5-2). Having the course for the indicated duration is not sufficient. With adult learners of additional languages the individual rate of acquisition varies, the quality and quantity of the outcomes differ and that the processes of learning a new language vary extensively. The cognitive abilities, the motivations and the personal predispositions of learners also play a vital role in the variation of additional or foreign language acquisition (Ortega, 2009). This may thus imply revisiting the curricula of these respective undergraduate programmes as well in order to integrate the communication course for all four years of students' studies.

6.3.2 Implications for further research

Although this study attempted to evaluate the effectiveness of the isiXhosa clinical communication course, further research into equipping students with the necessary knowledge and skills that they would need once they leave University, could be considered. This could entail compiling, for example, a pocket book that students can use during their year of internship, as well as for future reference. This pocket book could be designed to be discipline-specific with vocabulary and phrases in English, Afrikaans and isiXhosa for the use of healthcare professionals.

6.4 Limitations

A limited number of students and lecturers could be used for the purpose of this study. Three groups of students (n = 58) and one group of staff (n = 2) participated in the study. They included

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26 Human Nutrition students, 25 Occupational Therapy students, and seven Speech-Language and Hearing Therapy students.

Due to logistical challenges, students could not be observed in 'real life' contexts and therefore they had to be observed in simulation. Observations were restricted. Students could only be observed once and therefore students' communicative skills and their ability to meet the requirements of the communicator competency could only be determined based on one aspect of the content learnt throughout the clinical communication course. It would have been ideal to observe students on more than one occasion as they would possibly have engaged with patients experiencing different health problems. In this way students' competency level could be determined more effectively.

Only the profile (knowledge, skills and attitudes) of a Stellenbosch Occupational Therapist (see Chapter 2, section 2.4.1) could be described. Documents describing the profile of Human Nutrition and Speech-Language and Hearing Therapy graduates were not available. There is a profile available for the Stellenbosch Health Scientist. However, in terms of these three specific programmes (OT, SPH, HN), only the profile of the Stellenbosch Occupational Therapist was available.

6.5 Conclusion

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

However, the current isiXhosa clinical communication course implemented at Stellenbosch University, Faculty of Medicine and Health Sciences has proved to be more effective than general language programmes with a focus on grammar due to the fact that it has provided students with discipline-specific knowledge. Even though students have not acquired all the vocabulary and knowledge needed to communicate in a clinical context, the course enabled them to communicate with patients to some extent. It gave students the confidence to approach isiXhosa speaking

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patients and provided them with the necessary skills to build relationships. For an improved clinical communication course, continuous research and development work is essential.

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ADDENDUM A

DESCRIPTION OF CORE COMPETENCIES OF CANMEDS FRAMEWORK

Communicator

Being a communicator, it is the role of the health care worker to form positive relationships with patients and their families. To form a positive relationship, it is essential to gather and share important information for effective health care. As communicators, health care workers should actively listen to patients' experiences of illness. Communicators should explore feelings and expectations of patients regarding health care; they should integrate knowledge with an understanding of the patient's context. Being a communicator and enhancing a patient-centred approach involves shared decision-making regarding medical treatment between health care worker and patient, reflecting the patient's needs, values and preferences (Frank, 2015). Apart from establishing positive relationships with patients, it is also important to form relationships within a team.

Collaborator

As collaborators, health care workers should work effectively within a team of health care professionals to improve high-quality, patient-centred care. Patients, their families, health care workers and colleagues in the health care team, the community, and health systems stakeholders are involved. Being collaborators requires relationships that are built on trust and respect. Furthermore, it requires the sharing of knowledge, perspectives and responsibilities. To do this, understanding the role of others, as well as their differences, is important (Frank, 2015). Understanding and respecting each other's differences is an important quality of being a leader.

Leader

As leaders, it is the responsibility of health care workers to engage with others to ensure the delivery of effective patient care as clinicians, administrators, and scholars. It is important to

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demonstrate collaborative leadership and management in the health care system. Leaders also contribute towards continuous improvement of the health care system. Leaders function individually, within a team, and as participants in the health care system locally, regionally, nationally, and globally (Frank, 2015). Functioning within a team as leaders and collaborators, health care workers should further strive towards being scholars.

Scholar

As scholars, health care workers should demonstrate a lifelong commitment to continuous learning, by teaching others, and contributing to scholarship. It is important that health care workers acquire scholarly abilities to advance health care and to continuously evaluate various processes in the interest of quality and patient safety. They should strive to meet the needs of their patients and their families through multiple ways of learning. They should recognise the need to share knowledge and to facilitate the training of other physicians. Finally, the scholarly abilities of health care workers allow them to contribute towards the application, dissemination, and creation of knowledge applicable to health and health care (Frank, 2015). Not only should health care workers apply the acquired knowledge, but they should also share their knowledge.

Health Advocate

Health care workers should contribute their knowledge and expertise to patients and communities in order to improve health. They should work with patients in such a way to understand their needs. Health care workers should support their patients and improve the quality of health care by addressing the needs of patients, communities or the populations they serve. They should also increase the awareness of the importance of health issues at a patient, community, or population level. Due to the fact that health advocacy occurs within complex systems, it is vital to develop partnerships with patients, their families, support networks, and community agencies and organisations. Furthermore, health care workers should engage other health care professionals, community agencies, administrators, and policy-makers in a professional manner (Frank, 2015).

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Professional

As professionals health care workers play a key role in the health and care of society, it is important for them to commit to ongoing professional development, as well as the adherence to ethical standards such as integrity, honesty, humility, altruism, and respect. Thus it is important for health care workers to understand that they are accountable to those they serve, as well as to their profession (Frank, 2015).

Medical expert

Medical experts who need to provide high-quality patient-care, integrate all of the CanMEDS roles, applying medical knowledge, clinical skills, and professional values. It is the central role and draws on the six intrinsic roles (Communicator, Collaborator, Leader, Health Advocate, Scholar and Professional). It is the duty of medical experts to collect and interpret information, to make clinical decisions, and to carry out diagnostic interventions. Their decision-making is based on research evidence, available resources, as well as the patient's circumstances. Their behaviour should be professional and ethical (Frank, 2015).

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ADDENDUM B

STUDENT CLINICAL COMMUNICATION QUESTIONNAIRE

Dear student

Due to the fact that you have participated or are currently participating in the Clinical Communication Course at Stellenbosch University, Faculty of Medicine and Health Sciences, you are invited to take part in this study. The aim of the survey is to gather students' perceptions regarding the extent to which key communicator competencies are developed by the Clinical Communication Course.

Your responses to the questionnaire will remain anonymous at all times. Therefore, do not put your name on the questionnaire.

Please be honest when answering the questions. Your answers may ultimately result in recommendations for the improvement of the current course.

This questionnaire consists of two sections: 1) demographic section, and 2) communicator competencies. You only need to tick the appropriate block in each of the respective sections. It will take you approximately 10-15 minutes to complete the questionnaire.

Thank you for your participation.

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Section 1: Demographic information

1.1 Including the current year, how long have you participated in the clinical communication programme?

One year	
Two years	
Three years	

1.2 What is your gender?

Male	
Female	

1.3 How old are you?

19-20 years	
21-22 years	
23-24 years	
25+ years	

1.4 To what racial group do you belong?

African	
Coloured	
White	
Indian	
Other	

If other, specify: _____

1.5 What is your home language?

English	
Afrikaans	
English and Afrikaans	
isiXhosa	
Other	

If other, specify: _____

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Section 2: Communicator competencies

To what extent does the Xhosa Clinical Communication course contribute to developing the following competencies in you:

#	Competency	Not at all	Somewhat	To a considerable extent	Fully
1	To develop rapport, trust and ethical therapeutic relationships with patients				
Motivate your response:					

#	Competency	Not at all	Somewhat	To a considerable extent	Fully
2	To accurately elicit and synthesize relevant information and perspectives of patients and families				
Motivate your response:					

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#	Competency	Not at all	Somewhat	To a considerable extent	Fully
3	To accurately convey relevant information and explanations to patients				
Motivate your response:					

#	Competency	Not at all	Somewhat	To a considerable extent	Fully
4	To develop a common understanding on issues, problems and plans with patients to develop a shared plan of care				
Motivate your response:					

#	Competency	Not at all	Somewhat	To a considerable extent	Fully
5	To convey effective oral and written information about a medical encounter				
Motivate your response:					

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ADDENDUM C

INTERVIEW PROTOCOL

Semi-structured interview/focus group discussion: Lecturers

1. How would you describe the students' attitude towards the isiXhosa communication programme?
2. How are you attempting to meet the requirements of the communicator competency of the CanMEDS framework through your teaching of the isiXhosa communication programme? These requirements include:
   - 2.1 developing rapport, trust and ethical relationships with patients
   - 2.2 to accurately elicit relevant information and perspectives of patients
   - 2.3 to accurately convey relevant information and explanations to patients
   - 2.4 to develop a common understanding regarding health problems experienced by patients
   - 2.5 to develop a common understanding regarding treatment plans
3. To what extent is the isiXhosa communication programme effective in capacitating students to meet these requirements?
4. How do you think the isiXhosa communication programme could be changed to be more effective in this regard?

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ADDENDUM D

CLINICAL COMMUNICATION OBSERVATION

Observing student in clinical session with isiXhosa speaking patients unable to understand or speak English or Afrikaans

Section 1: Observation session details			
1. Date and Time:	2. Student observed:		3. Duration of observation:
Section 2: Competency 1 - Develop rapport, trust and ethical relationship with patients			
Competencies demonstrated	**Demonstrated**	**Not demonstrated**	**Comments**
1.1 Demonstrate a patient-centred approach in interactions with patients			
1.2 Demonstrate flexibility in the application of communication skills			
1.3 Establish positive relationship with patients in terms of trust, respect, honesty and empathy			
Section 3: Competency 2 - Accurately elicit relevant information from patients			
Competencies demonstrated	**Demonstrated**	**Not demonstrated**	**Comments**
2.1 Gather relevant information about			

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health problem experienced			
2.2 Effectively clarifying uncertainties by probing sensitively			
Section 4: Competency 3 - Convey relevant information and explanations accurately to patients			
Competencies demonstrated	**Demonstrated**	**Not demonstrated**	**Comments**
3.1 Retrieve patient-specific information from data system			
3.2 Deliver information to patient in an understandable way			
3.3 Encourage discussions and participation in decision-making			
Section 5: Competency 4 - Develop common understanding of problems and plans with patients			
Competencies demonstrated	**Demonstrated**	**Not demonstrated**	**Comments**
4.1 Identify and explore health problems experienced by patients			
4.2 Respect diversity (gender, culture, religion) in decision-making			
4.3 Effectively communicate in difficult situations with patients to			

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minimise confusion and misunderstandings			
4.4 Engage patients in shared decision-making regarding a plan of care			
Section 6: Competency 5 - To convey effective oral and written information about a medical encounter			
Competencies demonstrated	**Demonstrated**	**Not demonstrated**	**Comments**
5.1 To convey effective oral and written information about a medical encounter			
5.2 Present effective oral and written reports of clinical encounters			
Section 7: General comments regarding student behaviour			
General comments:			

_____

Observer name and surname

_____

Observer signature

_____

Date

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ADDENDUM E

PARTICIPANT INFORMATION LEAFLET

TITLE OF THE RESEARCH PROJECT:

Evaluating the isiXhosa clinical communication programme at a Health Sciences Faculty

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: Madelé du Plessis

ADDRESS: Faculty of Education, Dept Curriculum Studies, Stellenbosch University

CONTACT NUMBER: 021 938 9026

Dear Student

My name is Madelé du Plessis and I am an MPhil student. I would like to invite you to participate in a research project that aims to investigate the effectiveness of the current Xhosa communication programme.

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to accepted and applicable National and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

The purpose of the study is to determine the extent to which the isiXhosa clinical communication programme of the Faculty of Medicine and Health Sciences at Stellenbosch University satisfy the

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communicator competency requirements of the modified CanMEDS framework. More specifically, it is to determine 1) the extent to which the programme documentation of the current isiXhosa communication programme provide evidence of meeting the requirements of the modified CanMEDS communicator competency; 2) students' perceptions of the extent to which the isiXhosa clinical communication programme equips them to meet the requirements of the CanMEDS communicator competency; 3) the extent to which lecturers of the isiXhosa clinical communication programme attempt to meet the requirements of the modified CanMEDS communicator competency; 4) the extent to which observations of clinical consultations of students in the programme provide evidence of meeting the requirements of the modified CanMEDS communicator competency.

Anonymity is ensured and interviews, as well as surveys will be treated confidentially.

If you are willing to participate in this study please sign the attached Declaration of Consent and hand it to the investigator.

Yours sincerely

Madelé du Plessis

Principal Investigator

Stellenbosch University https://scholar.sun.ac.za

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled ……..

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…....…….. On (*date*) ……...…….. 2016.

.....

Signature of participant