Speaking Practice in the Medical English Classroom

Bridging the gap between medical English and the everyday world*

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Speaking practice is an important part of the language learning process, if the students are to master the language fully, but getting people to speak in the classroom is not always easy, because many students, especially adults, tend to feel inhibited. In ESP there is the added difficulty that classes are not always homogeneous, so that some participants will know more about a subject than others. In medicine, one way out of these difficulties is to present topics which are scientifically valid but of sufficient general interest to bridge the gap between medical English and the world of everyday experience. In this way everyone in the group may feel more personally involved and have something to say on the subject, which is perceived as stimulating but also relevant.

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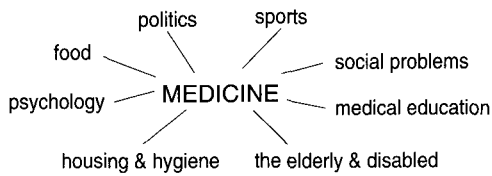
In ESP we often have students who are beyond school age and who come to the course with some previous knowledge of English. This does not mean, however, that we have to give remedial courses. As Swales (1990) points out, we must stand against the concept that we have nothing to teach by what should have been learnt before. Wilkins (1974) also referred to this problem of not repeating what was taught before but extending the students' knowledge by adopting a different organisation "so that the learning experience is a new and fresh one." We need therefore to offer learners something different from what they have already done and something, which is in line with their particular needs, otherwise motivation will be spoilt. In addition, we have to take account of the fact that each student may have a different learning pace and different expectations, so that it is necessary to adopt a flexible approach in our syllabus and methods.

There are medical English courses taking place not only in universities but also in other settings such as technical schools and hospitals, where the motivation of the learners may not be purely academic, and so there is a justification for integrating academic skills with others which are more akin to the needs of everyday life. In this way the student will see a personal relevance in the material presented and the kind of language he is exposed to and it becomes possible to build a bridge between medical English and the everyday world.

In these courses it is possible to enlist the personal involvement of the student in order to facilitate learning and probably also to help store material in the long-term memory as maintained by Stevick and others (Stevick 1982), because it is not enough to have understood a language item or rule, but the learner must also be able to remember it and eventually to interiorise it. The opportunity to relate with people around them and ask "How does this affect me?" undoubtedly helps people to communicate with the text or communicative event and also to talk to each other. This is a prime concern, owing to the well known fact that reading ability is far superior to speaking ability especially when people are given reading material from their own field, whereas speaking presents problems related not only to linguistic competence, pronunciation, awareness of appropriacy and pragmatic abilities, but also psychological factor. In fact, even though a student may be perfectly capable of forming correct and appropriate utterances, he or she may be unwilling to take the risk of speaking in front of the other students. It is necessary to pass through what Krashen has called the "affective filter" (Krashen 1981).

In the medical field we are perhaps more fortunate than teachers in other ESP courses, because whereas some sciences, such as the so-called hard sciences, are removed from the world of everyday life, medicine is a discipline which is concerned not only with laboratory research and hypothetical reasoning, but also has to do with people. It is thus possible to bring the outside world into the classroom and create activities based on authentic situations, using language which doctors and other health practitioners really use and for real purposes.

Here are some possibilities:



1. Starting off

The first lesson in a group often presents difficulties. We do not yet know the students and may have only rough idea of their level of competence. After doing some form of needs analysis and finding out something, about the students' expectations and levels of competence (usually before the beginning of the actual lessons), most teachers start off with an introductory talk. This serves to explain the content of the course and some of the techniques that will be used, and to start making the students feel at home in class so that they will be encouraged to take part as much as possible. The teacher needs to give the impression that the students are in firm hands, but at the same time to make clear that it is up to them to learn the language by committing themselves adequately and intelligently. After these general remarks, we could start off the activities of the first lesson by finding an area which links health and lifestyle, and so introduce some form of communicative activity - that is, one where the interlocutor asks questions to which he or she does not know the answer, and one which health professionals genuinely perform in real life. At the same time, in this first lesson we want something which will help the students to get to know each other, introduce a topic and some lexis pertaining to health and disease and discover weaknesses in their grammatical competence/knowledge which need to be attended to either at the end of the lesson or in a subsequent lesson. One solution is to use the students themselves as a resource and ask them to suggest things which we ought to do or avoid doing in order to keep fit. They thus have the opportunity to talk about themselves and their experiences. The teacher writes up their suggestions and so draws up a questionnaire based on their ideas, such as eating habits, exercise and so on, which can be in the present tense or in the past tense (referring to what they did yesterday), as preferred. Students interview a partner on the questionnaire.

Alternatively, we can base our questionnaire on those published in medical literature, such as those in the British Medical Journal, containing questions such as the following:

"Do you think the amount you smoke is harmful to your health?"

"Would you like to take more exercise?"

"Has your diet changed since the first interview? YES or NO.

If YES, are you eating less fat? less carbohydrate? (explain)."

After the pairwork, students can work out the score obtained according to their answers, which in itself is a useful activity involving the ability to read instructions in the scoring instruction sheet, or they can note down some advice to offer their partner as if they were advising a patient. This is a good opportunity to introduce various functions for giving advice such as "You ought to get more exercise", etc., and possibly some grammar/lexis on quantifiers, which are essential in medical English when it comes down to expressing numerical values and evaluating symptoms.

This can be followed by an authentic reading passage which is suitable for the type of professionals in the class. An excerpt from a reputable journal or textbook on, say, cancer and diets or one of the many articles published on correlations between heart disease and lifestyle are possibilities in the case of doctors and medical students. The students can summarize the passage in the form of notes or a table or flow chart.

2. Case studies and case conferences

We can use any number of activities as our starting off point for the lesson. Many doctors find it interesting to discuss a case study, and these offer plenty of scope for authentic problem solving tasks. It is important to choose a case which is not too difficult to diagnose, nor too obvious, and for this choice it is best to obtain advice from a medical expert first. If the teacher has little knowledge of medicine, this is no obstacle, because he or she can take a back seat and let the class take over. It is best to admit your lack of medical knowlege and not try to bluff your way through what Sheerin describes as "a minefield of technical jargon" (Sheerin 1977). In ninety percent of cases, it is not the technical vocabulary which the students do not know anyway, but the pronunciation of the words and the subtechnical or general lexis: they recognise "polydipsia" but may not know the word "thirst". A good pronouncing medical dictionary is essential. The teacher is at an advantage linguistically anyway and the learners will in fact probably feel more relaxed at speaking in front of a teacher who is just a

language expert and not a subject specialist, too, who might become an overdominant figure in the class. Adults are only too happy to show they know more than the teacher, because it is embarrassing for them to feel they are "back at school" having to study grammar and things they may have long forgotten. One word of warning, however: the teacher may admit ignorance of the specialist discipline, but must never give the impression that the subject itself is uninteresting or unimportant, because in this case the learners might feel offended.

The lesson can consist of different activities to suit the different learning styles of vocabulary input, with particular attention to pronunciation. Why not show a photograph of our imaginary patient to start with? This will give the impression that we are speaking about a real person. Visuals always help in making things more memorable. Then we can either listen to a recorded doctor-patient dialogue based on the case study or give each pair of students a pre-planned roleplay based on the same case. Let us imagine a case study has been chosen and a dialogue has been recorded previously by two of the teaching staff. After listening to the dialogue, the students are given a casebook description of the same case, in textbook prose format instead of doctor-patient dialogue form. The students can then attempt to reconstruct the dialogue from the prose passage, working in pairs or groups. After this has been practised sufficiently, attention is drawn to the linguistic differences between the two versions. A class with sufficient technical expertise can then hold a case conference to discuss for and against possible solutions to the case, as doctors do in real life. This is something which doctors find interesting and is therefore worth doing. This kind of authentic problem-solving activity may come close to satisfying the call made by D'Addio (1987) and others to apply some of the insights offered by language theorists in our teaching practice. Meanwhile, the teacher takes a back seat and one of the students chairs the conference. The teacher must also resist the temptation to intervene too much, being at an advantage in having read the case already and having the solution at hand.

A study of some common exponents of functions used in this kind of discourse is advisable. For example:

"Is the increased activity in the right femur consistent with either sepsis or metastasis rather than tumor?"

"In this clinical setting the activity shown on the bone scan is suggestive of metastatic tumor, although other causes cannot be excluded/we cannot count out other causes."

"A false aneurysm seems unlikely."

"That appearance does not fit the clinical findings in this patient."

"There is no history of palpitations."

"The echogram demonstrated/showed left ventricular hypertrophy."

"He had worked as a pipe fitter with known exposure to asbestos."

"He had/was given treatment for bronchitis."

In a more advanced class grammatical knowledge is not enough; some idiomatic knowledge is also necessary. Expressions such as "The condition cleared up in a few days" or "something is wrong, but I can't put my finger on it" are useful. Again, we must distinguish between the way patients speak and the way experts speak to colleagues. In one register we may find expressions such as "I have been feeling out of sorts", and in the other "The patient complained of fatigue and general malaise."

However, even if the participants are not qualified doctors, we can still organise a discussion, preferably in small groups, as long as we choose a case which offers opportunities to discuss broader aspects beyond the purely technical sphere. Thus, we can choose a disorder caused by outside agents, such as allergies, or with political or social implications such as connections between unemployment and disease or the sick house syndrome, which is so much in the news today. One student can fill in the blank diagram of a house while another inerviews the "patient". In this way the students have a purpose for speaking and can check the diagram afterwards with their partners, so that it is largely a self-correcting exercise.

The doctor-patient dialogue can lead into many kinds of transfer activites, such as writing case notes on the case or filling in forms, writing a letter of referral - hence switching to the third person and using suitable technical

terms as to a colleague, or presenting the case orally to a superior doctor at the patient's bedside, thus using rather different discourse techniques in the patient's hearing. Other tasks performed in real life by health professionals are: telephoning a hospital department or colleague, asking for certain tests to be carried out, reading path.lab. reports and discharge summaries, writing up a case report for publication in a journal and so on.

3. Subjects of general interest

What many teachers find is that classes are mixed, so that we may have postgraduate students and paramedics with different backgrounds and interests in the same group. Even if the class is entirely composed of doctors, they will come from different specialisations and there is the danger that if we choose a subject which suits one member of the class he will dominate the class discussion. Added to this is the fact that practising doctors are not always keen to talk shop all the time. A solution to these problems is to choose subjects which form a common denominator for different aspects of the medical sphere, such as medical ethics, which is of interest to anyone, or a subjec to such as acupuncture which few people in class may know much about. In a reading comprehension lesson, students are usually quite capable of doing comprehension exercises based on quite difficult texts, because the class (and the teacher) have the text before them, but otherwise people are often shy of talking in front of others unless their knowledge of both English and medicine is very good.

Free discussions on specialist subjects such as aetiology or pathogenesis of diseases are more difficult to get off the ground. This is where more general subjects with a bearing on medicine can come in very useful. By choosing subjects of general interest within the medical sphere, we can solve the problem of presenting material which is relevant and therefore motivating for the students without being perceived as threatening or too far removed from the individual student's particular field.

4. Reading and debating as group work

It is often stimulating to provide students with a reading text on a subject which is provocative or controversial in some way [what Brumfit (1977) has

termed "content regrouped"] to give students adequate practice in reporting on what they have read to different partners. They can attempt to arrive at a consensus of opinion and then prepare a written report on the text they have read, either as a group composition or individually. Most medical journals contain articles on problems such as ethics and bioengineering, abortion, terminal care and so on, which are suitable for discussion.

During these exercises, attention will be focussed more on meaning than on form. However, this does not mean that grammar explanations and exercises are excluded. The teacher will base these aspects of the course on the performance in each class, taking note of problem areas as students speak or write, without interrupting the flow of conversation during that part of the lesson which is devoted to fluency practice. It is useful to have a battery of exercises and tests at your disposal for accuracy training.

5. Beginners

Even for absolute beginners it is possible to devise appropriate tasks which are not beyond the ability of the students, such as the usual tasks carried out by the admissions officer in a hospital or a doctor interviewing a new patient. These include filling in a form with the patient's personal particulars, and later, once other tenses than the present tense have been mastered, questioning the patient on past history, family history and so on. The doctor-patient interview is a structured communicative event which involves the use of several different tenses. The doctor needs to know some suitable opening phrases to greet the patient and put him at ease. These form part of the phatic communion of this kind of discourse. Very soon, we find we need the present perfect, in order to ask "How long have you had this pain?," and the simple past to say "When did this start?"

As you can see, doctor-patient talk is by no means easy for beginners and needs to be introduced slowly. Even for intermediate students it will probably entail a lot of revision. If we teach structures which are characteristic of essentially medical matters, we will have solved the problem of reconciling general linguistic aspects of the language with specific needs of the students. The link between form and content is more motivating.

It is generally recognised that the acquisition of knowledge may bear little relationship to actual changes in behaviour. A student cannot be said to have fully mastered a structure, function or lexical item unless he has used it in a meaningful context, not just repeating it from the textbook. It is for this reason that speaking practice, both controlled and free, is so important and should be included in our syllabus if we can find time for it.

Here again, a word of warning is called for, however. Using articles from the popular press will not usually make the task any easier. To begin with, the discourse structure, lexis and linguistic features of popular articles are quite different from those of scientific journals, and are usually more difficult for non-native speakers rather than easier. The content is often not scientifically valid, as, for example, a mere hypothesis tends to be represented as a new "breakthrough" in scientific discovery. The vocabulary is often coloquial. In a serious scientific publication, although there may be idioms, we do no expect to find words such as "chum", "run riot" or "be up a gum tree", however popular they may be in newspapers, so it is not worth spending much time on them. High quality journals such as *The New England Journal, British Medical Journal* or *Lancet offer* a number of articles on current issues which are more reliable and more acceptable to an educated reader. We have to tread the fine line between stimulating interest and introducing pseudo science into the classroom.

WORKS CITED

Abe, D., Duda, R. and **Henner-Stanchina, C.** 1985. "A Specialist? What Specialist?" in *A Comparative Approach to the Learning of Specialized Written Discourse*. P. Riley, ed. London: Longman.

Allwright, Joan and **Richard**. 1977. "An Approach to the Teaching of Medicine" in *English for Specific Purposes*. Susan Holden, ed. London: Modern English Publications.

Beck, Eric et al. 1987. *Tutorial in differential Diagnosis*. Edinburgh: Churchill.

Bullard, Nicholas. 1981. "An Approach to the Teaching of English for Participation" in Medical Conferences" in *Recherches et Exchanges*. Paris: 6. No. 2.

Brumfit, Christopher J. 1977. "Commonsense about ESP" in *English for Specific Purposes*. Susan Holden, ed. Oxford: Modern English Publications.

—. 1986. *The Practice of Communicative Teaching*. London: Pergamon.

Calnan, James and **Andras, Barabas**. 1981. *Speaking at Medical Meetings*. London: Heinemann.

Candlin, Christopher, et al. 1977. *Doctor-Patient Communication Skills*. Lancaster: Medical Recording Service Foundation.

D'Addio, Wanda. 1991. "The Missing Link" in *Glottodidattica e Universita'*. Remo Job, ed. Torino: Liviana Editrice.

Krashen, Stephen. 1981. *Second Language Acquisition and Second Language Learning*. Oxford: Pergamon Press.

Murray, Anne. 1991. "Interactive Procedures Using Non-Specialist Texts" in *EMP Newsletter*. Liz Nakhoul, ed. Vol. 9:33-39. Edinburgh: Institute for Applied Language Studies, University of Edinburgh.

Sheerin, Susan. 1981. "Some Difficulties. Real and Imagined in Conducting Medical Case Conferences in the Teaching of Doctor/Doctor Language" in *Lexden Papers* 2:34-44. Oxford: Lexden Centre.

Stevick Earl, W. 1982. *Teaching and Learning Languages*. Cambridge: Cambridge University Press.

Swales, John M. 1990. *Genre Analysis: English in Academic and Research Settings*. Cambridge: Cambridge University Press.

Wilkins, David. 1974. *Second Language Learning and Teaching*. London: Edward Arnold.