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Training matters

Teaching English to psychiatrists from overseas

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The Institute of Psychiatry accepts approximately 30 postgraduate students each year from overseas countries. The composition varies, largely as a result of international economic changes, and since 1977 students from 60 countries have attended (Appleby & Araya, 1990). Knowledge of English also varies and can influence the training of a student in many ways. Difficulties in understanding and communicating with patients, colleagues and teachers can adversely affect study, clinical practice and examination performance. MRCPsych results are poorer for non-UK than for UK doctors (Cawley, 1986): one reason may be poor communication.

Such problems are well known to foreign students in all medical specialties and are particularly important in psychiatry where language is central to clinical assessment and treatment. As overseas psychiatrists fill posts created by *Achieving a Balance* and the Royal College Overseas Doctors Scheme, the disadvantage may become more widespread.

In their first term at the Institute of Psychiatry, doctors enter a 10-week introductory course designed to prepare them for ward-based clinical study, course components including clinical lectures, case conferences and seminars on developing world psychiatry (Hollander, Appleby & Checkley, 1988). Since 1986 the course has also included tuition in English, taught by lecturers from Goldsmiths College, London. We describe the teaching of English for psychiatric practice and study, which we believe to be the only course of its kind.

Course objectives

The Teaching of English as a Foreign Language has been adapted to psychiatry. To communicate with patients and colleagues, doctors require a knowledge of vocabulary, colloquialism, intonation and gesture. If possible, they should also be familiar with aspects of speech which British people take for granted – subtle formalities, irony, disguised commands and mock deference. Specifically, teaching is directed at the following:

(1) Everyday use of English (in contrast to standard teaching)

Example:

Standard version:

Q: Is anyone sitting here?

A: No, no-one's sitting there.

Everyday version:

Q: Is anyone sitting here?

A: (waves hand dismissively) Go ahead.

In this everyday reply, there is a potentially confusing conflict of speech and body language.

(2) Use of the appropriate register, i.e. suitable language for the situation, the person spoken to, or whether speaking or writing.

Example: Doctor to patient (giving reassurance, quasi-informal): I think it would be helpful for you to come into hospital so that we can look at the things that are worrying you.

but

Doctor to colleague (seeking confirmation, semi-formal): Would you agree that this patient would benefit from admission for assessment?

(3) Interpretation of material relevant to psychiatry, e.g. newspaper accounts of mental disorders.

(4) How inflection and word order can alter meaning.

Example: The expression "how interesting" has many meanings, ranging from "how *really* interesting" to "how unutterably boring", depending on the tone of voice.

(5) Linguistic subtleties.

Example: "As a *person*, I don't *like* John . . ."

When the emphasis is on *person* and *like*, it is clear that the speaker is going to concede grudgingly that John is, nevertheless, a shrewd academic or skilful clinician.

(6) How non-verbal communication may be culturally determined.

Example: Doctors from Japan, where smiling can indicate a lack of understanding, may misinterpret smiles from European patients.

Course design

Each unit of the 50-hour course is designed with the above objectives in mind. The precise content is flexible enough to allow for different levels of language, both within one group and from year to year. Each session begins with the reading of a short test relevant to mental health, presenting a specific point of grammar or vocabulary. Later, videotaped interviews enable students to explore clinical areas of language use by focusing on what a patient actually says, on how he or she says it and on interview technique. So, using a professionally relevant context, important linguistic topics are addressed.

Course content

(1) *Written texts*

(a) Text organisation

Verb tenses and items of vocabulary create cohesion in a test.

Example: (Newspaper article on PTSD):

"At the first European conference on post-traumatic stress held in Lincoln last month, researchers told participants that the stress and uncertainty of not knowing what had happened could be so great that psychologists should classify it as a disorder, 'the questioning syndrome'."

Cohesion here is created by a series of linked references e.g. conference-researchers-participants; stress and uncertainty-it-the questioning syndrome.

The same extract also demonstrates superordinate areas of vocabulary (words which can be grouped together by subject matter) e.g. disorder-syndrome-trauma; conference-researchers-participants.

Particular phrases are seen to have an invariable construction. Conferences, for example, are *held,* disorders are *classified,* conferences are held *on* a particular subject.

(b) Tenses and structures

These are the nuts and bolts of language learning. For English students learning a foreign language, it recalls lists of irregular verbs but it is more usefully about how verb tenses are constructed and, more important, the situations in which they are used.

Example: The same newspaper report contains interviews with disaster survivors employing narrative tenses:

"I was trying to get to the lifeboat when I passed out".

Students are presented with such a sentence modified as below and asked to work out the correct tense from the infinitive.

"I (try (get) to the lifeboat when I (pass) out."

(c) Linking words

At their most basic, these are and, but and or; enumerative groupings such as first, secondly, thirdly; or time references such as yesterday, today and tomorrow. More sophisticated or academic elaborations include furthermore, in addition, above all, in conclusion and accordingly. Sentences from a text are presented in random order and from this students must produce a coherent sequence. This is a vital skill for preparing case notes or articles and for following lectures.

(d) Overt and covert meaning

Consider this pair of sentences:

Example: Families should be given time to grieve.

and

Families must be given time to grieve.

Although the first statement is overtly in the form of a recommendation, it implies as much command as the second. The disguise is discussed: it may be a device to indicate deference to an audience; it may be a ploy to play down the speaker's eminence in a field.

(2) *Videotaped interviews*

(a) Nuances of expression

Nuances of manner and pronunciation may lead to widely different clinical conclusions.

Example: Compare –

(irritated and miserable) "Everything is against me".

and

(intense and fearful) "Everything is against me"

The first statement here may indicate depression; the second a paranoid psychosis.

(b) Evaluation of clinical material

This is useful in two ways. First, it enables students to experience different levels of fluency and different regional accents, which can be impenetrable at first hearing. The patient may struggle for words to express barely understood emotions; the doctor may struggle with the patient's non-standard English, so that analysis of what the patient is trying to say will be lost in the attempt to understand the direct speech.

Example: An utterance such as

"I've got a lot on my mind at the moment"

can, through the process of elision, dropped consonants and vowel changes, appear to sound like

"Oi've go' a lo' on m'min' a ' th' momen' ".

By being aware of how words are condensed and that 't' and 'd' are frequently dropped, the student can reconstruct sentences into understandable English. Clinical material is also a rich source of idioms and accepted slang, which students can group or categorise, as in:

I feel down/down in the dumps/browned off/fed up.

Secondly, clinical material provides a realistic context in which students can practise newly acquired language, giving the teacher the chance to monitor the ease with which language is being used. Unlike

live clinical situations, here students can refer back to the video material as often as needed.

(3) *Follow-up language practice*
This includes some or all of the following:

(a) taking history notes from a videotaped interview (formal-written)
(b) giving an account of a case for newspaper publication (informal-written)
(c) the same, for presentation at a clinical conference (formal-spoken)
(d) Class discussion of treatment (semi-formal-spoken)
(e) Role play explanation of treatment to a patient (quasi informal-spoken).

(4) *Further developments of the course*
As students' one-to-one skills become more polished, interactional ability can be addressed. This includes holding and gaining attention in groups such as clinical conferences. Such behaviour is in part culturally determined and both speech and body language have a function.

Example: There are many ways of interrupting a speaker who is holding the floor, some requiring prior exaggerated agreement or apology as well as certain body movements:

A: So I feel that we should discharge this patient ...
B: (leans forward, attempts to catch A's eye): Could I just say ...
A: ... under the supervision of a community nurse ...
B: (raises finger, shifts position in chair): I'm sorry to interrupt ...
A: ... although I realise that not everyone may agree ...
B: (nods with increasing vigour): Yes ... I take your point but ...

And so B gains the floor and is able to disagree

Course results

Assessment is continuous without formal testing. Objectively students are seen to gain in fluency, competence and accuracy. They themselves report improvement in both confidence and subjective competence.

When the course ends, the students begin working directly with patients in whom they must assess subjective mood, suicidal intent, family discord, ambivalent attitudes, speech disorder and delusions, all in a foreign language. For this intimidating task the course offers a foundation in the real use of English across a variety of clinical situations, accents and dialects. In doing so it should also allow effective learning, good patient care and exam success.

References

APPLEBY, L. & ARAYA, R. (1990) Postgraduate training in psychiatry 1977–1987: Disturbing trends in the pattern of international cooperation. *Medical Education*, **24**, 290–297.

CAWLEY, R. H. (1986) Overseas graduates and the MRCPsych. *Bulletin of the Royal College of Psychiatrists*, **10**, 60–63.

HOLLANDER, D., APPLEBY, L. & CHECKLEY, S. (1989) Mental health education for primary health care. *Psychiatric Bulletin*, **13**, 73–76.

Achieving Resource Management

A national exhibition and conference will be held on 30 November 1990 in the New Connaught Rooms, Great Queen Street, London. This event is supported by the Department of Health and it will gather together virtually all the major hardware and software systems used in support of resource management and medical audit. Further information: Jane Statham, Conference Manager, Mercia Publications Ltd., The Science Park, University of Keele, Keele, Staffordshire ST5 5SP (telephone 0782 625056; fax 0782 717732).