ENGLISH FOR SPECIFIC PURPOSES (ESP):

NURSING IN THE U.S. HOSPITAL

A Project
Presented
To the Faculty of
California State University, Chico

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Teaching International Languages

by

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ENGLISH FOR SPECIFIC PURPOSES (ESP):

NURSING IN THE U.S. HOSPITAL

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Laura Medlin

Fall 2009

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DEDICATION

To all my hard-working brothers and sisters, in hospitals everywhere.
ACKNOWLEDGMENTS

Dr. Hilda Hernandez and Dr. Paula Selvester.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Publication Rights</th>
<th>iii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dedication</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>v</td>
</tr>
<tr>
<td>List of Tables</td>
<td>ix</td>
</tr>
<tr>
<td>Abstract</td>
<td>x</td>
</tr>
</tbody>
</table>

## CHAPTER

### I. Introduction

- Purpose ........................................................................ 3
- Scope ........................................................................... 6
- Significance ................................................................ 8
- Project Goals .......................................................... 10
- Limitations .................................................................. 11
- Definitions .................................................................. 12
- Acronyms Frequently Used ......................................... 13

### II. Review of the Literature

- English for Specific Purposes .................................... 18
- Learner Motivation .................................................... 20
- Needs Analysis .......................................................... 22
- Classroom Application .............................................. 23
- Hospital Language ..................................................... 27
- Idioms and Metaphor ................................................... 29
- Economy and Slang ..................................................... 31
- Grammar and ESL ....................................................... 33
- Description .................................................................. 34
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 9: Recommended Books and Websites ................</td>
<td>65</td>
</tr>
<tr>
<td>Contents ................................................................</td>
<td>65</td>
</tr>
<tr>
<td>Rationale ................................................................</td>
<td>65</td>
</tr>
<tr>
<td>Chapter 10: Reader Questionnaire ..........................</td>
<td>65</td>
</tr>
<tr>
<td>Contents ................................................................</td>
<td>65</td>
</tr>
<tr>
<td>Rationale ................................................................</td>
<td>65</td>
</tr>
<tr>
<td>IV. Discussion .................................................................</td>
<td>67</td>
</tr>
<tr>
<td>Summary ...........................................................................</td>
<td>67</td>
</tr>
<tr>
<td>Conclusions .................................................................</td>
<td>68</td>
</tr>
<tr>
<td>Recommendations ...........................................................</td>
<td>69</td>
</tr>
<tr>
<td>Suggestions for Instructors .........................................</td>
<td>70</td>
</tr>
<tr>
<td>Suggestions for Students .............................................</td>
<td>71</td>
</tr>
<tr>
<td>References ......................................................................</td>
<td>73</td>
</tr>
<tr>
<td>Appendix ...........................................................................</td>
<td></td>
</tr>
<tr>
<td>A. Nurse ESP Handbook for U.S. Hospitals: The Professional Language of Nursing</td>
<td>79</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical Characteristics of Six Hospital English Books</td>
<td>46</td>
</tr>
<tr>
<td>2. Features of Six Hospital English Books</td>
<td>47</td>
</tr>
<tr>
<td>3. Useful Elements in Developing Nursing ESL/ESP Materials</td>
<td>48</td>
</tr>
</tbody>
</table>
ABSTRACT

ENGLISH FOR SPECIFIC PURPOSES (ESP):
NURSING IN THE U.S. HOSPITAL

by

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Master of Arts in Teaching International Languages
California State University, Chico

Fall 2009

Advances in medical technology have increased the human life span, and as elderly populations increase, so will jobs in healthcare. Unable to find a book specifically targeting American English for nursing, this need has been met by designing material for nurses and language instructors. The project provides a general overview of the workplace setting and review of the literature organized around three areas: English for specific purposes, hospital language, and cultural aspects of patient care. Within these three areas, the topics of content-based language instruction and learner motivation, medical terminology and abbreviations, and how cultural background can influence a person’s response to illness and hospitalization are addressed. There is a review of six books related to medical English and English for nurses and healthcare professionals. Most of these books are designed for physicians, and emphasize British English.
This project involves the creation of a prototype for a handbook on teaching American Hospital English to nurses and other healthcare professionals who are not native speakers of English. The handbook consists of ten chapters on the topics of body systems, patient care, weights and measures, a glossary of terms, a Basic Life Support lesson plan, medical transcription templates, the nursing process, patient privacy and the legal language of healthcare, recommended resources, and a reader questionnaire. A preliminary section addresses the needs of instructors by outlining information on meeting state and national standards for English as a second language and foreign language instruction. Suggestions for further research and reference tools are also included.
CHAPTER I

INTRODUCTION

There are many different ways of viewing the hospital, and the many roles it plays in different countries, cultures and communities. For example, as well as a place where disease is cured, and suffering alleviated, it can also be seen as: a refuge; a factory; a business; a temple; a university; a prison; a city.

(Helman, Culture, Health and Illness)

The U.S. acute care setting is a fast-paced, complex and often chaotic working environment. Nursing personnel are required to converse with many different types of people on a variety of topics. They function as liaisons between patients, physicians, family members, and other staff. Nurses must remember medical information and organize work to fit within time constraints while multi-tasking. There are many distractions and unforeseen interruptions and emergencies. It can be busy, noisy, demanding, and frustrating. Patients and visitors are often fearful and under tremendous stress. The hospital environment is rich and complex, and worthy of study and analysis as an ethnographic speech community.

Many factors can influence communication between laypeople and hospital staff, such as a patient who is sleep deprived or receiving narcotic medication. Giger and Davidhizar (2004) list some of the many factors affecting the communication process, such as a client’s physical health and emotional well-being, the senses involved and their functional ability (such as hearing), and distractions in the noisy and hectic hospital
environment. The client’s background, including cultural, social, and philosophical values, level of education, as well as past experiences relating to the current situation will have an effect on his or her perception of the situation being discussed and its meaning (Giger & Davidhizar, 2004, p. 24).

Advances in medical technology, therapies, and interventions have increased the human life span. As people live longer, they often develop age-related health issues and problems requiring medical attention and subsequent hospitalizations. Nettina (2006) asserts that “by the year 2030, the over age 65 population will more than double to about 70 million. Almost 50% of the U.S. population has one or more chronic conditions” (p.3). As elderly populations increase, so will jobs in the healthcare industry. Nurses who speak languages other than English are working in the U.S. healthcare market, and more will continue to seek jobs in the U.S. Many will need instruction in the type of English language skills required to work and communicate effectively in the busy hospital environment.

This paper explores the subject of English for Specific Purposes (ESP) for nurses in U.S. hospitals. It is organized into four chapters. Chapter 1 introduces the topic and outlines its purpose, scope, significance, limitations, and some definitions of terms. The project began as an attempt to fill the void of a lack of materials specific to ESP for nursing by merging these two fields of study. One goal is to begin a dialogue on the topic and to encourage others in the field to develop materials. This project is limited to a preliminary and general overview of this subject.

Chapter 2 consists of a review of relevant literature. Three areas of focus are ESP, the language of the hospital setting, and aspects of culture as it relates to patient
care situations. Content-based language instruction and learner motivation are two key elements of the ESP portion. In addition to Greek and Latin derivations, important language forms are abbreviations and agentless passives. Functions include the language of description. The complex nature of culture and how it impacts a person’s response to illness and hospitalization encompasses issues such as non-verbal communication, privacy, and concepts of health and illness.

Chapter 3 describes the methodology involved in creating a handbook specific to American Hospital English (AHE) for nurses. Six books on the subject are reviewed. Most of these books are geared toward British English for physicians. The ten chapters of the handbook are outlined, and some criteria for their design are explained.

Chapter 4 contains the summary, conclusions, recommendations, and references. Suggestions for further development of materials are offered to instructors and students.

Purpose

With few exceptions, there has been little attention given in the field of TESOL or ESP to refugee/immigrant students in nursing and other professional health-care programs. (Bosher & Smalkowski, From Needs Analysis to Curriculum Development: Designing a Course in Health-care Communication for Immigrant Students in the US, English for Specific Purposes)

The central aims of this project are to integrate subjects studied in the MA degree program in Teaching International Languages (TILS) at California State University (CSU) Chico, in the design of a handbook and other materials about ESP for nurses in American hospitals. The focus is on authentic language embedded in a meaningful
context, relevant to direct patient care and work situations. Material has also been compiled that could function as the foundation for a course in ESP, specifically for use in American hospitals by nurses and other personnel.

With respect to a potential audience for this type of material, a study conducted by Bosher and Smalkowski (2002) provided a needs analysis of culturally diverse students enrolling in nursing programs in Minneapolis. They describe how the five student nurses in their study commented that “communicating with clients often caused greater anxiety than the actual procedures they performed” (p. 62). The results of their interviews and observations showed that the student nurses experienced difficulties in areas such as being assertive, communicating clearly and effectively, understanding clients, appropriate non-verbal skills, such as eye contact, small talk, asking for help, cultural differences, and charting appropriately (p. 64).

Students from other countries wishing to study English for the healthcare professions here in the U.S. vary in their personal and professional backgrounds. It is necessary and beneficial to conduct a needs assessment in order to custom-design effective language instruction. The California State Department of Education (CDE, 1990) describes the needs of learners in the ESL Handbook for Adult Education Instructors. One consideration is educational background. Educational systems and style vary in other countries, and students may be accustomed to lectures and individual study, rather than group activities. They may have been taught to be silent in class. Learners who have extensive educational backgrounds have an easier time in the classroom than those who have had limited education. How does an instructor conduct a needs assessment if the students have limited English skills? He or she can use visuals, props, or give students
opportunities to act out nursing tasks, such as taking a blood pressure manually, to demonstrate what they know. Pictures can illustrate skills and situations, and the students can indicate by nodding whether or not they are familiar with the material, or perhaps matching or categorizing like items or equipment (p. 6). Needs assessment can operate at various levels; the L1 can also be used, depending on the number of languages represented. Linguistically, it is important to determine what languages they know and how their first language, or the language of instruction in their schools, compares to English in syntax (structure) and orthography (alphabet). In addition to reading and writing ability, nursing students in the U.S. need instruction and practice in casual conversation, and listening to lectures. These four skills can be assessed individually, to tailor instruction so as to help students learn best. For example, if a student has an extensive educational and professional background, and is comfortable academically with reading and writing in English, he or she may need more practice in verbal communicative activities. Students may come from a wide range of socioeconomic backgrounds, some growing up in rural and others in urban environments. Many factors in students’ personal lives can affect their ability to function successfully in a classroom, such as cultural background, family and/or personal responsibilities, and physical and emotional health. They may be fatigued and overstressed with work and personal familial obligations.

It has been difficult, thus far in the research, to locate a handy, comprehensive, all-in-one resource which suits the needs of students and instructors. The desired product is a handbook containing much of the information needed to teach an ESP course for hospital work. The journal articles and books read tend to focus on the work and needs of international physicians and research scientists, or emphasize British English.
This handbook will be designed to prepare individuals for work in U.S. hospitals or other clinical settings. It may also be used as a teaching tool, a reference text, or an independent study resource for individuals wishing to improve their communicative skills at work, or preparing for a specific exam. It could be used to facilitate communication and efficiency in the workplace. The content could help reduce stress for individuals who may feel overwhelmed by their work and responsibilities in the clinical environment. They might bring personal scenarios and struggles from work to share as classroom input, exchange ideas and connect with fellow classmates.

This project merges two areas of work and study: nursing in an American hospital, and the study of language learning and teaching. The author is a native English speaker, currently employed as a registered nurse (RN), in a critical care bedside capacity.

Scope

*The need for English as a professional language in medicine is nowadays beyond doubt. Scientific literature and the internet are just two examples that reveal the overriding necessity for understanding and expressing ourselves in written and spoken English.*

(Ribes & Ros, *Medical English*)

This project is limited to the English language used by nurses and other healthcare team members in American hospitals, in direct patient care situations, and in communicating with co-workers. The language of the hospital is derived from and includes the language of medicine. The art of *medicine* involves diagnosing and treating diseases. Medicine is practiced by physicians, surgeons and other medical professionals, and English for medical purposes is, by definition, used by those practitioners. Nurses, in
contrast, care for patients by following the orders of physicians and treating the patients’ response to illness. The American Nurses Association (ANA) offers this definition of nursing work from 1980: “Nursing is the diagnosis and treatment of human responses to actual and potential health problems” (Nettina, 2006, p. 2). This leads to a discussion of the language of the nursing conceptual model, which includes the nursing process, thus distinguishing it from the medical model.

“The Nursing Process is a deliberate, problem-solving approach to meeting the health care and nursing needs of patients” (Nettina, 2006, p. 5). This consists of assessing the patient and collecting data, formulating a nursing diagnosis, and developing a plan of nursing care for the patient. “The ANA has recognized several standardized languages for nursing to document the nursing process and nursing care. Standardized languages are important for computerized documentation systems, for tracking care over the continuum, and for studying the impact of nursing care” (p. 5). The North American Nursing Diagnosis Association (NANDA) has developed a list of approved nursing diagnoses, called the Taxonomy II. There is a specific three-part format for a nursing diagnosis, consisting of a patient problem, its etiology, and signs and symptoms (see Appendix A, Chapter 7). For example, a patient with a medical diagnosis of pneumonia may experience, “Activity Intolerance related to infection as evidenced by shortness of breath upon exertion” (Venes, 2005, p. 2723). The theory and use of nursing diagnoses and their taxonomy are subject to debate among nurses over whether or not they are effective or beneficial in the workplace. Dealing with the language subtleties and semantics involved can be confusing, even for native speakers of English. Usually, this type of language isn’t used in spoken interaction, but it is required to get through nursing programs, take the
licensing exam, and write patient care plans. The licensing exam developed by the National Council of State Boards of Nursing (NCSBN), is called the NCLEX-RN (The National Council Licensure Examination for RNs). It is “used by state, commonwealth and territorial boards of nursing to assist in making licensure decisions” (NCSBN.org, test plan section, p.1). Each state has its own Board of Registered Nursing, and its own Nurse Practice Act, and nurses must be careful to remain with their scope of practice.

The term medical English is often used in blanket fashion to include all the language of healthcare. While it is true that some aspects of medical language are used by all members of the healthcare team, and the language of healthcare is derived from the language of medicine, for the purposes of this project, the terms medical English and English for medical purposes are reserved for medical practitioners. Although the language used by nurses and other members of the healthcare team could be referred to as “hospital English,” “English for healthcare workers,” or “English for nursing care,” as reflected in the title of this paper, the author has chosen to use the term AHE.

Significance

They must learn hundreds of strange, complicated hospital expressions. In making out a chart or writing a hospital report they face a language problem even if they had been honor students in their English classes at home.

(Jordheim, I teach hospital English, The American Journal of Nursing)

The content of this project includes the subject of ESP and the healthcare occupations, content-based instruction, second language learner variables, medical terminology and the language of the hospital, and cultural aspects of patient care. This material may be helpful to second language-learners (SLLs), especially those seeking jobs in
hospitals or planning to attend nursing schools. If they have experience in healthcare in their home countries, but have limited English ability, then they can use this material to become familiar with the U.S. educational system, as well as its healthcare system. It may also prove useful to TESOL instructors, nursing instructors, or other healthcare professionals interested in this subject.

The format of this project consists of a review of relevant literature, and a discussion of nursing work in the hospital. The methodology includes a review of six books on hospital English. Appendix A is a prototype nursing ESL handbook, consisting of ten chapters. Chapter 1 includes samples of nursing assessment documentation and translations of medical jargon into lay terminology, organized by body systems. Chapter 2 includes the language used in patient care situations. Chapter 3 is a glossary of frequently encountered abbreviations. Chapter 4 is a table of weights and measures specific to nursing work. Chapter 5 consists of a lesson plan created for teaching Basic Life Support (BLS) to English language learners, with a communicative task of phoning and speaking with a 911 operator. Chapter 6 is a sampling of medical transcription templates to assist nurses in locating patient information. Chapter 7 outlines some of the language used in writing nursing diagnoses. Chapter 8 offers information regarding HIPAA (Health Insurance Portability and Accountability Act), Patient Rights, and DPAHC (Durable Power of Attorney for Health Care) policies. Chapter 9 lists some recommended texts and websites. And finally, Chapter 10 is a reader questionnaire to garner feedback on ways to improve this handbook.

Jordheim (1954) writes of her experiences (over 50 years ago), with Norwegian nurses adapting to work in the U.S. “Procedures which they have carried out many
times in their own countries become difficult. I know there is a difference between hospital terms in America and England” (pp.1124-1125). Nursing and healthcare have become more complicated since the writing of this article and nurses are required to care for more complicated patients. Could it be true that more texts about English for nursing haven’t been published in the last fifty years? It is hoped that this project will stimulate discussion and encourage ESL/ESP research and instruction that targets nurses and other healthcare workers in the U.S.

Project Goals

The goal of this project is to create something that will be of value to nursing students, nursing instructors, ESL and ESP students and instructors, and other English language learners interested in studying English for the healthcare professions. Included among the desired outcomes of this project are the following:

1. To meet a definite need in the field.

2. To increase awareness of the lack of specific American hospital English materials designed for nurses.

3. To shift the focus away from British usage and medicine to nursing and other healthcare occupations in the U.S. market.

4. To encourage a professional dialogue on this topic.

5. To explore the various communicative modes—written, spoken, heard, and read—of American hospital English.
6. To develop materials, such as instructional units and lesson plans, for English language teachers who wish to teach English for the healthcare occupations, and to provide access to the resources necessary to begin to develop their own materials.

7. To develop independent study materials and resources for those interested in the healthcare field.

8. To examine and adapt existing healthcare textbooks and study materials for use in the ESL classroom.

9. To encourage research concerning the best methods to teach American hospital English to nurses and other healthcare team members.

Limitations

This project consists of a preliminary and general overview of some of the topics and language involved in working in U.S. hospitals. Its author draws on personal experiences working in such capacities as a certified nursing assistant (CNA), unit secretary, licensed vocational nurse (LVN), phlebotomist, and RN, in acute and long-term care facilities in California. The author is familiar with the job descriptions and duties required of these positions, as well as their educational program designs.

Each state has its own Board of Nursing and particular laws and regulations governing healthcare. And each healthcare organization has its own unique policies, procedures, and administrative terminology. The equipment and supplies used in each individual facility may vary, as well as the brand names. There are many different clinical specialty areas, each with its own unique terminology, supplies and procedures.
Instructors in healthcare vocational schools may have their own unique regional dialect and slang, so the language may vary somewhat among these settings.

No copies of official documents or patients’ medical records (see Appendix A, Chapter 8) are included in this project. Instructional materials of this type would necessarily contain extensive illustrations. However, due to time constraints and copyright laws, no illustrations are included here.

No classroom research or research using human subjects has been conducted. There is no compilation of data or statistical information.

This subject matter, American Hospital English, is vast and a thorough and comprehensive exploration is beyond the scope of this project. This is a general examination, linguistic analysis, and overview of this specialized workplace setting.

Definitions

*Acute care*: “Health care delivered to patients experiencing sudden illness or trauma. Acute care generally occurs in the prehospital, hospital, or emergency department and is usually short-term rather than long-term or chronic care” (Venes, 2005, p. 39).

*Authentic materials*: Instructional materials taken from real-life contexts, such as a CPR manual used to teach English language for specific purposes (Jordan, 1997, pp. 113-114).

*Colloquial*: “Of or relating to informal conversation” (Mish, 1996, p. 226).

*Communicative competence*: The ability to communicate in the target language; the goal of the language classroom (Brown, 2001, pp. 68-70).
Comprehensible input: A message in the target language that learners can understand (Krashen & Terrell, 1983, p. 55).

Contextualized: Language embedded in a real-life context, as opposed to fragmented, abstract language. Methods of contextualizing language include using visual aids, hands-on materials (manipulatives), photographs, and diagrams (Echevarria & Graves, 2003, pp. 55-58).

Macroskills: Listening, reading (receptive skills), speaking and writing (productive skills) (Dudley-Evans & St. John, 1998, pp. 95-120).

Medical terminology: The specialized language of medicine, derived mostly from Latin and Greek (Ribes & Ros, 2006, pp. 117-119).

Acronyms Frequently Used

BLS: Basic life support. The process of assisting a person’s breathing and circulation in the event of a cardiac or respiratory arrest; CPR (Venes, 2005, p. 1239).

CBI: Content-based instruction. Language teaching using subject matter (e.g., science) as the means (Mohan, 1986).

CPR: Cardiopulmonary resuscitation. Procedures to assist breathing and circulation, such as rescue breaths and chest compressions, for a person experiencing cardiac or respiratory arrest (Venes, 2005, pp. 1891-1895).

DPAHC: Durable Power of Attorney for Health Care. Designating someone to make medical decisions for you in the event that you become incapacitated (Oxley, 2006).
**ELL:** English Language Learner. “Students for whom English is not their native language” (Echevarria & Graves, 2003, p. 2).

**ESL:** English as a Second Language. English language instruction for non-native speakers of English (though English may be a third, fourth, or even fifth language for the learners) (Crystal, 2003a, p. 108).

**ESP:** English for Specific Purposes. ESL taught for a specific field, such as engineering or business (Mohan, 1986, p. 15).


**NANDA:** North American Nursing Diagnosis Association. “Exists to develop, refine and promote terminology that accurately reflects nurses’ clinical judgments” (www.nanda.org).

**NCLEX-RN:** National Council Licensure Examination for Registered Nurses. Nurses must pass this multiple-choice test to be licensed in the U.S. There is also an

**NCLEX-PN:** Exam for Licensed Practical Nurses (LPNs). In California, the title is Licensed Vocational Nurse (LVN) (www.ncsbn.org).

**NCSBN:** National Council of State Boards of Nursing. Oversees NCLEX (www.ncsbn.org).

**NNS:** Non-native speaker. A person speaking a language which is not his or her first language (Crystal, 2003a, p. 359).

**SLA:** Second language acquisition. The process of learning to communicate in a language which is not one’s first language (Echevarria & Graves, 2003, pp. 44-48).
**SLL:** Second language learner. A student of a language which is not their first language (Brown, 2001, pp. 116-117).

**TOEFL:** Test of English as a Foreign Language. “Test takers prove they are ready for academic success with the TOEFL test—the most widely accepted English-language assessment test in the world” (www.toefl.org).

**TESOL:** Teaching English to Speakers of Other Languages. Also, TESOL, Inc., “a global association for English language teaching professionals” (www.tesol.org).
CHAPTER II

REVIEW OF THE LITERATURE

The subject of AHE can be approached from several different angles. One may undertake an ethnographic study of the environment, examining the socio-cultural dynamics and workplace hierarchies. One might transcribe conversations, creating a corpora-based discourse analysis. Medical terminology, which consists largely of Greek and Latin morphemes, and grammatical elements of scientific writings provide a rich context for linguistic analysis. The medical documents alone are vast and worthy of study. Physicians’ interactions with patients, such as the doctor-patient interview, comprise a large portion of the discourse. The business and management of healthcare, finances, insurance, legalities and all the associated economic implications are current topics of interest. Modern medical technology and scientific research have a global impact on epidemiology and spark ethical debates. The psychology of illness, roles of patient and caregiver, and theories of medicine and nursing are other complicated topics.

Roberts (2005) identifies the four main approaches used in research about English in the workplace: textual analysis of discourse, interactional sociolinguistics, pragmatics, and ethnography. These methods focus on the rule-governed nature of speech and written genres, differences of communicative style and misunderstandings, social and cultural patterns of interaction and the values, beliefs, and assumptions that account for such interaction (pp. 122-123).
This project focuses attention on what would help non-native English speakers working in the hospital get through their shift and how to best teach them. This may include something from each of the above research approaches. First, one must examine the language. Verbal communication occurs in face-to-face interaction, on the telephone, within group discussion, in lectures and in-services, and announcements over the intercom. Forms of written communication include documents, progress notes, physicians’ orders, nurses’ notes, dictation, memos, textbooks, research articles, reference materials, specialized terms and abbreviations, and informal notes and messages. At times, nurses must interpret nonverbal communication as well as communicate nonverbally. Cognitive impairments such as brain injury, dementia, delirium and psychosis and other psychological stressors have an effect on the interpersonal communication process. Individual temperament, life experience, and philosophical orientation can also influence how people communicate.

Out of the potentially endless amount of material that could be explored, the focus has been narrowed and limited to three areas relevant to the topic of AHE for nursing: elements of teaching ESP, the language of the hospital environment, and cultural aspects of patient care. First, the topic of ESP has been selected because it is a specialized form of English as a second language (ESL) for adults interested in a particular field. It encompasses the type of classroom environment in which to teach hospital English. Second, it is necessary to get to know students and to design instruction that best meets their needs. Learner motivation and elements of content-based instruction are addressed as a foundation for designing the curriculum. The language of the hospital environment is the content to be taught. As instructors must know the subject they teach, a linguistic
analysis of this content will increase awareness of language forms and help explicate these rules to learners. Communicating effectively in the hospital is the goal of instruction. Finally, culture influences one’s response to illness and hospitalization. As different cultures come into contact amid stressful circumstances, it is important to be sensitive to potential areas of misunderstanding that can lead to communication breakdown. Nurses are taught to strive for therapeutic communication at all times during patient care. An awareness of culture and how it affects one’s experience in the hospital can facilitate more effective and therapeutic communication. Each of these topics is addressed in the sections that follow.

English for Specific Purposes

*At its simplest, an occupation can be identified solely by its lexicon.*

(Crystal, *The Cambridge Encyclopedia of the English Language*)

ESP is ESL instruction for a particular speech community, occupational field, or workplace situation. The basis of ESP is the teaching of language using content or subject matter. The teaching of AHE would fall into such a category: workplace or occupational ESL. Master (2005) states that ESP is often taught in other countries, but “ESP goes under different guises in the U.S., such as content-based instruction or workplace ESL” (p. 101). This section discusses elements of teaching ESP and AHE. Topics include content-based instruction, theme-based instruction, the importance of learner motivation, discovering the students’ needs and how to meet those needs, and classroom application.

Many authors describe content-based instruction for adults as well as for younger learners (Brown, 2001; Chamot & O’Malley, 1994; Dudley-Evans & St. John,
This type of teaching “puts the emphasis on communicating information, not on the language used” (Mohan, 1986, p. 9). English is taught using the core curriculum as the means; the second language is the medium used to convey informational content that interests the learners (Brown, 2001, p. 234; Echevarria & Graves, 2003, p. 8). Within CBI instruction, Dudley-Evans and St. John (1998) differentiate between real content and carrier content: “In ESP, any teaching activity, whether its aim is to teach language or skills, is presented in a context” (p. 11). So, an authentic topic is chosen to function as the context, as a vehicle to “carry” the real content, which may be certain language forms. For example, in a lesson on preparing and administering an injection, to teach the language of steps in a sequence, the task of giving the injection would function as the carrier content, while the language of sequence is the real content. Thus actual workplace situations can be used to teach adults in ESP classes.

Chamot and O’Malley (1994), with their Cognitive Academic Language Learning Approach (CALLA) designed for K-12 students, distinguish between three types of function in memory: long-term, short-term, and working memory. They state “We modify and expand on information in long-term memory based on new information that is stored in short-term memory or manipulated while in working memory” (p. 13). Chamot and O’Malley (1994) explain that two types of knowledge, declarative and procedural, are also included in this cognitive model:

Declarative knowledge consists of “what” we know or can declare, and procedural knowledge consists of the things that we know “how” to do. Declarative knowledge is stored in memory frameworks or schemata that are interconnected concepts and ideas. There is no reason to believe that the memory schemata in one language cannot be used to assist solving problems or understanding similar information in a second language, provided that the concepts in each language are similar. Procedural knowledge is stored in memory as
production systems. Production systems consist of a series of steps in which there is a “condition” and an “action.” (pp. 13-14)

They also suggest that “teachers should learn to recognize declarative and procedural knowledge in content materials” (p. 19). Although the above methods are designed for K–12 classrooms, many of the teaching strategies can also be applied to the adult ESL and ESP contexts.

Inherent in ESP and CBI are subject themes or topics. Dirkx and Prenger (1997) outline integrated, theme-based instruction (ITBI) for adults in all kinds of classes, not just ESL. The authors describe methods on motivating adult learners, creating a supportive classroom environment, and designing theme units based on the adult learners’ needs (p. 19). ITBI is based on contextual learning. “Simply put, contextual learning refers to learning that students find meaningful, relevant, and significant to their situation and life experiences” (p. 19). Elements of theme-based instruction can be applied to all ages and subjects.

Learner Motivation

This section addresses the key factor in language learning success, learner motivation. Krashen and Terrell (1983) assert that “All human beings can acquire additional languages, but they must have the desire or the need to acquire the language, and the opportunity to use the language they study for real communicative purposes” (p. 17). Motivational forces can be described as intrinsic, extrinsic, integrative, and/or instrumental. Intrinsically motivated behavior is its own reward, because it stems from internal needs, wants, or desires; it is what the learner brings to the classroom. Extrinsic motivation stems from the anticipation of an external reward, and part of that reward is what the
classroom offers (Brown, 2001, p. 58-59). Echevarria and Graves (2003) present Baker’s (1992) definition of integrative motivation as stemming from a desire to identify with or integrate into a particular language group. In contrast, “instrumental motivation describes a situation in which individuals learn another language for a practical reason, such as getting a job, enhancing their career possibilities, or passing an exam” (p. 45).

Research by Schumann (1997) explores how “stimulus appraisals generate mental activity that enhances or inhibits learning” (p. 8). Stimulus appraisals derive from homeostats and sociostats, inherited mechanisms that cause humans to seek out survival-enhancing conditions, attachment and social affiliation. Homeostats and sociostats lead to idiosyncratic preferences and aversions throughout life (pp. 1-2). According to Schumann (1997), when one encounters stimulus situations, these situations “are appraised according to the accrued history of an individual’s preferences and aversions” (p. 2). “Events appraised at helping individuals reach their goals were associated with joy, and those hindering goal-achievement were associated with anger” (p. 11). “Emotional reactions influence the attention and effort devoted to learning, and patterns of appraisal may underlie what has been considered motivation in SLA” (p. 8). Diaries show that stimulus appraisals are highly individualized, based on one’s life experience. A relatively negative experience can be motivating, and vice versa. In some cultures, competition in the classroom is a motivating force. Students can feel comfortable in various types of classroom environments based on personal preference.

Content is motivating for ESL students. They focus on subject matter and topics they are interested in, and develop important skills they can use (Brown, 2001;
Chamot & O’Malley, 1994). But interesting themes and content in ESP instruction must be accompanied by students who wish to learn the material.

Needs Analysis

When teaching or designing a course in ESP, one goal is to strive to meet the learners’ needs. In order to discover who the learners are, what they already know, and what they want from the class, it is important to conduct some type of needs analysis. Many adult students studying English in the U.S. have extensive educations (most likely in a language other than English), and professional work experiences, as well as significant life experiences. Perhaps they were engineers, physicians, pharmacists, medical technologists, or nurses in their countries. They bring well established work and study habits, preferred learning styles, and so on. They possess a greater knowledge of the world (Chamot & O’Malley, 1994, pp. 84-85; Knox, 1986, pp. 20-21; Krashen & Terrell, 1983, p. 46). But needs analysis applies to learners of all ages and levels.

Research articles by MacLean, Betancourt and Hunter (2000) and Shi, Corcos, and Storey (2001) describe how ESP courses were specially-designed to meet the needs of medical students and doctors in Hong Kong and Cuba. In Hong Kong, lectures at the University are conducted in English, but the staff and students speak Cantonese. Communication between the patients and doctors is also in colloquial Cantonese. The medical students are required to interview and assess the patients and immediately translate their findings into English. “Students find the highly complex process of almost simultaneous recall, synthesis, interpretation and compression of information, as well as the translation of some of it into an L2, both cognitively and linguistically demanding” (Shi et al., 2001,
These students’ particular needs included practice in code-switching, and in developing and using more English descriptive terms and time reference markers.

According to MacLean, Betancourt, and Hunter (2000), workshops were set up by the Ministry of Public Health in Cuba to provide English language training for doctors sent to work overseas (p. 18). “Doctors asked for conversation classes and gradually more occasional short courses for groups of doctors were set up” (p. 22). Despite economic setbacks, instructors were determined to continue with the evolving programs to meet the needs of their students.

Knox (1986) suggests that “the most valuable information you can obtain in order to help people learn something is what they already know about the subject” (p. 38). Chamot and O’Malley (1994) encourage deliberate planning in how to activate students’ prior knowledge (pp. 84-85).

Classroom Application

After finding out what students want and need from the class, and working to motivate them, the next step in ESP instruction is how to teach the material. In order to create an effective classroom environment, Krashen and Terrell (1983) insist that “the best situations for language acquisition seem to be those which encourage lower anxiety levels” (p. 38). Classroom activities that focus on topics which are interesting and relevant to the students, allowing them to express ideas and opinions and transmit messages, are most effective (p. 21). “Factors that contribute to a low affective filter include positive orientation to speakers of the language, acquiring in a low anxiety situation, and at least some degree of acquirer self-confidence” (pp. 19-20). The authors also describe how
caretakers of young children simplify their speech when talking to them. Three notable aspects of caretaker speech are that it is motivated by the caretaker’s desire to be understood (the purpose is to communicate), it is structurally simpler than language adults use with each other, and it is about “the here and now” (supported with context) (p. 34). Echevarria and Graves (2003) also emphasize the importance of modified speech on the part of the teacher:

Another unique component of sheltered instruction is reducing the linguistic load of teachers’ speech. Natural but slower speech, clearly enunciated, can increase comprehensibility, particularly when effort is made to use shorter sentences with simpler syntax. The use of more pauses between phrases allows students time to process what has been said before the next utterance begins. Repetition, or natural redundancy, reinforces language. During instruction, use consistent vocabulary as much as possible. To expand vocabulary, communicate the same idea repeatedly using different words. (p. 60)

Some aspects of two variations on teaching content in a second language can be applied to the adult ESP setting: Sheltered English Instruction and Specially-designed Academic Instruction in English (Brown, 2001; Echevarria & Graves, 2003; Mohan, 1986). Sheltered instruction was originally designed for K-12 students attending U.S. schools who were in the process of learning English. Echevarria and Graves (2003) state that “sheltered instruction functions as a support until the student is ready for mainstream classes” (p. 8). Grade-level content, such as science, is made accessible to English language learners while at the same time teaching them English (p. 53). SDAIE is another form of sheltered instruction. “SDAIE is grade-level subject matter in English specifically designed for speakers of other languages” (Sobul, 1995, p. 3). Some features of SDAIE teaching are a low affective filter (reduction in anxiety and emotional resistance),
modified speech (perhaps this can be deemed *caretaker speech*), contextual cues, and multisensory experiences (California State Department of Education, 1993; Sobul, 1995).

Chamot and O’Malley (1994) suggest that students be provided with an overview of the major points of the lesson and taught content as experiences rather than merely as facts (p. 33). Mohan (1986) recommends that along with the overview, instructors emphasize the main knowledge structure in the topic (p. 28). Mohan (1986) also states that an activity combines theory (background knowledge) and practice (action situations) (p. 45). An action situation is the specific, practical aspect, the “here and now” context (p. 53). “The teacher communicates through action situations, where the circumstances make the meanings clear” (p. 106).

Casual conversation is prevalent in the hospital environment. Sociolinguistic competence, or the ability to engage in casual conversation easily in the target language and culture, is an important workplace skill. Holmes and Fillary (2000) recommend classroom activities that allow learners to practice workplace small talk, as well as watching realistic soap operas set in workplaces such as hospitals and offices (p. 286). But the authors also caution that “the sociolinguistic competence which underlies the ability to use talk in interaction successfully is typically acquired gradually over years of experience and exposure to language in different contexts” (p. 276). Marshall (2002) recommends the creation of a type of simulation lab in the classroom to accustom English language learners to the behavioral expectations of the U.S. workplace: “Allocating class time for discussion of cross-cultural differences and expected behaviors in the U.S. will help learners develop and practice these patterns of behavior and interaction skills” (p. 71).
The type of interactional language patterns and conversations that learners encounter and engage in comprise the discourse of the hospital setting. Mohan (1986) suggests using recorded dialogues (from the situations where the learners will actually interact) and situational role plays to practice talking (pp. 48-49). This type of activity consists of contextualized dialogue (p. 57). Shi et al. (2001) observed discourse functions of medical students at work, and developed an English enhancement course based on their analyses (p. 270). Activities observed included taking and presenting the case, describing and reporting the physical exam, interpreting and making diagnostic hypotheses, description of symptoms, and giving instructions to patients (p. 272). Dudley-Evans and St. John (1998) assert that learners store vocabulary as chunks of language, or lexical phrases that are frequently used in certain situations (p. 86). It is beneficial for learners to practice the types of dialogues that occur in the hospital, using common phrases and authentic materials. “Materials play a crucial role in exposing learners to the language, which implies that the materials need to present real language, as it is used, and the full range that learners require” (Dudley-Evans & St. John, 2001, p. 171). These examples describe elements of teaching language using content as the means.

Content-based instruction focuses on communicating information, not on the language used. Students learn best if they are motivated and comfortable. Conducting a needs analysis and designing thematic units based on information the students want and need may increase their motivation. Sociolinguistic competence is the goal for the workplace, and classroom exercises should be based on authentic language situations. The next section discusses aspects of the specialized language used in a hospital setting.
Hospital Language

A physical exam is a reading of the body by naming and describing.

(Shi, Corcos, & Storey, Using student Performance Data to Develop an English Course for Clinical Training, English for Specific Purposes)

The language of the hospital setting comprises the content to be taught in the ESP classroom. Three terms come to mind when considering an occupation and its accompanying language: register, jargon, and lexicon. A register, as defined by Crystal (2003a), is “a socially defined variety of language, such as scientific or legal English” (p. 467). Jargon refers to “the technical language of a special field” (p. 464). The vocabulary of a language is its lexicon (Crystal, 1987, p. 424). Within the realm of healthcare and AHE, the use of Greek and Latin elements to create medical terminology is obvious. There are many medical terminology textbooks that teach the roots and affixes that form medical nouns, adjectives, and verbs. For example, hepatitis is formed from the root hepat-, pertaining to the liver, and the suffix –itis, meaning inflammation. The adjective myocardial comes from myo-, muscle, and cardio-, heart. A foundation in anatomy and physiology is necessary to describe the structures and functions of the human body, and their spatial orientation, using Greek and Latin terms.

The topic of sub-technical language use in the hospital is addressed by Arakelian, Bartram, and Magnall (2003):

There are many words which are used in everyday life, but have a special meaning when they are used in the hospital. It is half-way between general usage and highly technical medical language. It is often the cause of communication breakdown between native and non-native speakers, or between users of American and British English. (p. 55)
Examples include words such as *drip* (an intravenous medication), *rhythm* (heartbeat), *gas* (a blood test), *negative* (a good test result), *stone* (a British unit of weight), and *echo* (a diagnostic study of the heart).

With respect to written forms of communication, Marco (2000) examined grammatical frameworks in medical research papers, and noted the prominence of *nominalizations* and *agentless passives* (p. 64). As defined by Crystal (2003b), a nominalization is the process of forming a noun from some other word-class, or the derivation of a noun phrase from an underlying clause (e.g., red + ness) (p. 314). Nominalizations, as well as agentless passives, hide the human agents, emphasizing the entities studied, rather than the researcher’s actions (Chamot & O’Malley, 1994; Marco, 2000, p. 65). An example of an agentless passive is the sentence “the research was conducted” (a form of *be* + a past participle), as opposed to “the scientists conducted the research.” The author suggests that “students can improve their ability to understand and write medical papers if they are made aware of the function of these frameworks in the paper” (p. 75). Frequently in nursing documentation, when charting about one particular patient, the pronouns *he*, *she*, and the word *patient* are omitted, unless another person is brought into the narrative, such as a family member, for example, “up and into chair; took 100% of breakfast. Complains of headache; medicated for pain; states medication relieved headache.”

Chamot and O’Malley (1994) state that the grammatical forms of the passive voice, multiple embeddings, if . . . then constructions, and expository discourse used in scientific prose may be difficult for ESL students to comprehend (p. 195). A study conducted by Ferguson (2000) focused on if-conditionals in naturally occurring medical discourse (p. 61). “Conditionals can function as a resource for politeness in face to face
interaction. Another common use of conditionals is in the description, or the elicitation, of symptoms” (p. 76). The author notes that there is a difference in the use of if conditionals in spoken and written medical discourse. Perhaps this type of research would assist the English language teacher in identifying linguistic forms in order to explain their usage to students.

Idioms and Metaphor

Conversational skills involve varying one’s style of speech depending on the situation at hand. In the hospital or other healthcare environments, many different styles of speech can be heard through the course of a day. Two intriguing language forms (which are not unique to English, but occur in other languages as well) are *idioms* and *metaphors*. An *idiom* can be defined as “a sequence of words that is a unit of meaning (e.g. *kick the bucket* = *die*)” (Crystal 1987, p. 423), or “an expression in the usage of a language that is peculiar to itself either grammatically or in having a meaning that cannot be derived from the conjoined meanings of its elements” (Mish, 1996, p. 575). Campbell (1995) states,

From a linguistic viewpoint, idioms are expressions with meanings that are *noncompositional*. These often complex expressions can’t be understood by adding together the meanings of their constituents. An idiomatic expression may violate grammar, and it often violates logic. (p. 125)

Francis (2004) created an idiomatic expressions workbook specifically for ESL students. He describes how frustrated learners often feel outside of the classroom, listening to native speakers chatting, and not being able to understand it all. His exercises embed idiomatic expressions in realistic dialogues that students will encounter, because, “context is
the key to making the daunting task of understanding and using idiomatic English not only possible, but enjoyable too” (p. i).

Several authors discuss metaphor (Lakoff & Turner, 1989; Master, 2000; Mustacchi & Krevans, 2001). Crystal (1987) defines metaphor thusly, “two unlike notions are implicitly related, to suggest an identity between them” (p. 70). An example could be, as mentioned in Helman (1997), the perception of the human body as a machine (p. 26). In his review of ESP research, Master (2000) states that “the single microlinguistic concern in English for Occupational/Professional Purposes (EOP/EPP) was the use of occupational/professional metaphors” (p. 105). Lakoff and Turner (1989) claim that we use metaphor as a tool, unconsciously and automatically (p. xi). According to them, “Metaphor plays an enormous role in shaping one’s everyday understanding of everyday events. It is central to our understanding of ourselves, our culture, and the world at large” (p. 214). Mustacchi and Krevans (2001) describe how metaphor has affected the field of medicine in the U.S since the jargon of the insurance industry and cost accountants was introduced after the Medicare Act of 1965, and the patient became the consumer. Medicine was once seen as a ministry to the sick, but this ethical and religious metaphor is being replaced by a business metaphor (p. 14). “Medicine has borrowed a metaphor from the commercial marketplace that is altering our medical culture. Increasingly, medicine is being perceived as a product rather than as a service” (p. 16). Idioms and metaphors in English are important for teaching conversational skills. They are used frequently in the workplace, as in every conversational setting. Native speakers may not even be aware of their usage, as they are a natural part of discourse, used unconsciously. Interacting with patients and co-workers requires conversational skills. Here are some examples of
phrases heard in the hospital that a non-native speaker may not be familiar with: “She’s barely treading water, and I’m afraid she’s going to konk out”; “Let me get my bearings, I need my sea legs”; “OK, let’s give it a whirl”; “The patient is crashing and burning.”

Economy and Slang

The hectic pace of the work setting, fatigue from talking and writing, and time constraints demand economizing of the language via abbreviations as much as possible. Written pieces will be abbreviated with a type of medical shorthand. Before, after, with, without, regarding, secondary to and related to are all phrases that can be reduced to one or two letters. Latin and Greek terms can substitute for whole descriptive sentences and are less subject to multiple interpretations, such as the term anuric to be used in place of “not making urine.” In other situations, where time is of the essence, slang terms can be utilized to denote an emergency, such as “crashing” or “coding” to describe a rapid decompensation in a particular patient’s health status. Some types of acronyms used in the hospital are initialisms and alphabetisms. Initialisms (e.g., MI and CHF) “reflect the separate pronunciation of the initial letters of the constituent words,” whereas alphabetisms (e.g., CABG and OSHA) are pronounced as a single word (Crystal, 2003b, p. 1). Clipped forms or clippings are types of reductions, such as the term echo used in place of the word echocardiogram, and narcs instead of narcotics. A very common word in English is stuff; it can replace a long list of names of items and supplies needed for a particular task or procedure, as in, “Do you have all the stuff?” Busy hospital staff also appreciate quick and concise reference tools, such as tables, charts, and formulas.
In many countries, British English is the mode of instruction for English language learners. In a review of six books on medical English, some British terms that are not used in most U.S. healthcare situations were noted. A brief list of some British terms with their American-style equivalents is included in Appendix A. Among the differences between American (AmE) and British English (BrE) used in hospitals, one is spelling: –or/our; -er/re; e/ae; e/oe, which really doesn’t pose a problem in regards to spoken interactions. Pronunciation differences are noted in stress patterns, as in the word \textit{laboratory}: \textbf{lab-o-ra-to-ry} (AmE) vs. \textbf{la-bor-a-tory} (BrE) (the American-style pronunciation can be confused with the British \textit{lavatory}). The vowel sound ‘a’ can be long in BrE and short in AmE, as in the words \textit{after} or \textit{half} (Crystal 2003a, p. 306). Crystal (1987) claims that it is quite possible that a nurse who understands and speaks English in his or her home country may have difficulty understanding patients and staff members using colloquial, U.S. English, and vice versa. A \textit{colloquialism} is “a local or regional dialect expression; conversational; informal” (Mish, 1996, p. 226). \textit{Slang} is “informal, non-standard vocabulary” (Crystal, 1987, p. 430).

There are regional varieties within the U.S., and even within certain communities. One word that comes to mind is \textit{wash}; some native English speakers pronounce it as “wosh” and others “worsh.” Stern (2002) provides definitions using a limited number of words, some of the most frequently encountered words from their English language corpus. This format has influenced the list of translations designed to assist NNSs in translating medical jargon into laypersons’ terms (Appendix A, Chapter 1). Giger and Davidhizar (2004) advise us to avoid too much medical jargon with NNSs who only have a partial understanding of the language. “An individual usually first understands standard
words and picks up slang expressions and professional terms at a much later stage of lan-
guage acquisition” (p. 38). They also caution that ELLs may not grasp the full meaning
of puns and humor and may misinterpret jokes (p. 34).

Grammar and ESL

The ESP setting can be likened to an ESL classroom, and many ESL students
struggle with certain grammatical forms. Hacker (1998) and Campbell (1995) note that
the articles *a*, *an*, and *the* may be troublesome, because many of the world’s languages,
such as Asian, Slavic, and African, don’t include articles. Crystal (2003b) defines articles
as “a subclass of determiners which displays a primary role in differentiating the use of
nouns . . . a distinction is usually made into definite and indefinite types” (p. 33). Are
articles really necessary to communicate information? In the hospital context, “need gur-
ney” would communicate the meaning of “I need a gurney” clearly. Another problem
area can be that of *count* and *non-count* nouns:

  Countable, *count*, or *unit* nouns are those denoting what the language treats as
  separable entities, by using them with such forms as *a*, *many*, *two*, *three*, etc.
  Uncountable or *non-count* nouns are treated as continuous entities, having no
  natural bounds, by being used with such forms as *much* or *some*. The contrast
  can be seen in *a boy* v. *much boy*, and *information* v. *much information.*
  (Crystal, 2003b, p. 114)

  The use of prepositions, words that “typically precede noun phrases to form a
  single constituent of structure, a prepositional phrase” can be difficult (Crystal, 2003b,
  p. 368). A phrase such as “do you want to get *at* bed?” would be understood if combined
  with body language of patting the bed with one’s hand; the context helps clarify meaning.
  Two-word verbs can be tricky, such as to *go over* (something), or *fill* (something) *
  up* (Campbell, 1995, pp. 74-139; Hacker, 1998, p. 403). If a speaker’s primary language
doesn’t have the same form of gender pronouns as in English, the speaker may, at times have trouble with appropriate use of *he* or *she*. Native speakers are usually tolerant of this from NNSs, but can be rather unforgiving of a native speaker who makes the same kind of error. Brown (2001) lists some language forms that can make listening difficult for non-native speakers, such as clusters, redundancies, reduced forms, colloquial language and rate of delivery (pp. 252-254). Clearly, learners can benefit from listening exercises, particularly with samples taken directly from the workplace.

**Description**

Much of the language and discourse of the hospital involves describing what is seen or perceived, or events that have taken place. This can be divided into *subjective* and *objective* observations. Subjective data include descriptions of perceptions or feelings, particularly what the patient states about his or her condition. Objective findings aim at being more scientific, specifically what can be measured or observed by many people. The metric system is used to document size and volume (cm, mm, liters, and ml) for consistency and accuracy, but occasionally common cultural references are employed, as in “a dime-sized bruise.” Adjectives are required in documenting location, position, size, color, shape, pattern, distribution, frequency, direction, regularity. Greek and Latin terms are used for these, again for consistency and accuracy. Certainly if the NNS’s primary language is derived from Latin, he or she will have an advantage in memorizing and/or interpreting the descriptors. Examiners utilize the tools of sight (inspection), touch (palpation), hearing (auscultation), as well as analyses of blood and radiological images in their assessments. Atkinson (1995) devotes a whole chapter to “reading the body.”
author explores how by the use of tools such as x-rays and microscopes, the body is rendered legible and transformed into a type of text which can then be read by competent investigators (pp. 60-65).

Shi et al. (2001) discuss some common problems among medical students in Hong Kong involving temporal reference, tense usage errors, and absent or incorrect time markers. Students also lacked appropriate expressions to describe precise characteristics of clinical signs, and had difficulties in describing location and procedures in physical exam reports (p. 269). The authors note that “Cantonese differs from English in its heavy reliance on time markers to signal time relations, rather than on a combination of verb forms and time markers together” (p. 279) and that “many other students were observed to lack descriptive terms” (p. 281). This research demonstrates how some students can benefit from exposure to and practice in the language of description.

The language of medicine and science form the foundation for the language of healthcare. The intimate nature of the work of caring for the sick involves basic conversational skills and colloquial speech. The busy work environment demands code-switching back and forth between technical jargon and colloquial layperson’s language, and frequent use of abbreviations. American slang and idiomatic expressions can be problematic for non-native speakers, as well as the metaphors that shape our view of life, death, health, illness, the hospital environment and medicine. Knowledge of the patterns in written forms of hospital communication and the language of description are necessary tools for healthcare work and documentation. To adapt authentic materials for the classroom, one must be able to identify and explain certain linguistic forms and usage. The
following section discusses how culture can impact patient care and the work of the nurse.

Cultural Considerations

*Regardless of cultural background, listening is one of the most effective therapeutic techniques. The need to communicate respect for the client is a nursing concept that crosses all cultural boundaries.*

(Giger & Davidhizar, *Transcultural Nursing: Assessment & Intervention*)

Caring for the sick involves intimate contact with patients and interacting with their friends and family members. “*Culture* refers to the integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, and/or social groups” (Lipson & Dibble, 2005, p. xi).

**Pain**

A patient’s cultural background will influence his or her response to illness and hospitalization. One important aspect of illness is pain. It’s easy to think of pain as a biological phenomenon with an involuntary, universally-accepted response exhibited by all people. Reactions, however, can be involuntary (instinctual), or voluntary. The response to pain and how that is communicated to others can be described as *pain behavior*. Some involuntary physical reactions are increased heart rate and blood pressure, facial grimacing, tensing of muscles, and withdrawing from the source of the pain. Voluntary reactions, and how or whether people communicate their pain to health professionals, are particularly influenced by social and cultural factors (Helman, 1994, pp. 179-180). The attitudes that a particular cultural group has toward pain, such as it being a
normal and accepted part of life, may influence their reaction to it and/or their way of communicating it to others (Helman, 1994, p.182). The patients may lack the vocabulary needed to adequately relate or describe their pain in the target language. In the hospital, we usually use a numerical pain scale from 0-10, or rate it as mild, moderate, or severe. If the patient is unable to communicate verbally or is in a medically induced coma, we observe physiological responses, such as heart rate and blood pressure to gauge the pain or distress level.

Privacy

Another important issue in the American hospital is patient confidentiality. The physician will speak first directly to the patient, and others will be asked to leave the room, unless the patient requests that they stay. The first authority is the patient, alone. Information about the patient, which includes the chart and medical record, is private and confidential. If the patient is unable to communicate, then it is the legal spouse or person with a Durable Power of Attorney for Health Care (DPAHC), or other immediate family member who is making medical decisions for the patient (see Appendix A, Chapter 8). The patient’s chart and medical record are confidential. The patient must give approval and sign a release of medical information form in order to share any information. No patient information can be given out by staff members over the phone to family members and friends, regardless of how close the relationship. Even a question such as “What medicine are you giving her?” is a violation of the Health Insurance Portability and Accountability Act (HIPAA) and personal privacy. Another area of misunderstanding can be the family wishing to speak with the physician, in which case nurses must act as liaisons. The physician does not have time to speak with several family members, so it is
recommended that families designate one spokesperson. Nurses strive to promote patient privacy and rest, and have a legal obligation to do so. Familial orientation can be troublesome at times, when having several people at the bedside is not conducive to a therapeutic patient environment. Also, children are discouraged from visiting the hospital to avoid or minimize the transmission of viruses to vulnerable patients.

**Time**

Simply put, for many Americans, and especially those working in the hospital, time is money. “A general attitude shared by health care professionals is that time is irreplaceable and irreversible and that to waste time is to waste life” (Giger & Davidhizar, 2004, p. 114). The reality of work in the hospital is that very often nurses and other staff are required to complete more tasks than they are physically able to complete within a given time frame. This means they must allocate time and resources for the most pressing (particularly life-threatening) issues first. Unfortunately, this means that some patients and families will not receive as much attention as they would like. Since healthcare is viewed as a service, and the patient as a paying customer, it is difficult for many people (particularly Americans) to tolerate not getting five-star service at all times, as in a hotel or restaurant. Some cultural groups have different perceptions of time, deeming *social time* more important than *clock time*. When people of different cultures interact, there is great potential for misunderstanding (Giger & Davidhizar, 2004, p. 111). “Nurses are constantly being challenged to work in a more time-efficient manner, causing high levels of stress” (Giger & Davidhizar, 2004, p. 114).
Personal Space

Helman (1994) describes the boundaries of the body using the terms intimate distance, personal distance, social distance and public distance (pp. 16-17). Different cultural groups may have unique rules about these distances. “The need for space serves four functions: security, privacy, autonomy, and self-identity” (Giger & Davidhizar, 2004, p. 58).

All cultural groups have rules, often unspoken, about who touches whom, when, and where. It is important to consider gender and modesty; patients may prefer a nurse of the same gender to care for them. Males generally have a larger personal space than females have. “A nurse should stay within the rules of touch that are culturally prescribed. It is essential that the nurse uses touch judiciously and avoids forcing touch on anyone” (Giger & Davidhizar, 2004, p. 32).

Non-verbal Communication

Body language and styles and types of feedback may be unique to certain cultural groups (Giger & Davidhizar, 2004, p. 24). Many Americans value eye contact as a symbol of attentiveness and sincerity especially during conversation. These same people may interpret a lack of eye contact as shyness, rudeness, dishonesty, or a “leave me alone” message. But “other groups who find eye contact difficult include some Asian people and some American Indians, who relate eye contact to impoliteness, and an invasion of privacy. Many American Indians regard eye contact as disrespectful” (Giger & Davidhizar, 2004, p. 33). Silence can be uncomfortable for some Americans, but some persons in Asian cultures may view silence as a sign of respect, particularly toward elders. “Nurses need to be aware of possible meanings of silence so that personal anxiety
does not promote the silence to be interrupted or to be non-therapeutic” (Giger & Davidhizar, 2004, p. 30). Facial expression, posture, and proximity can punctuate the spoken message.

**Blood and Illness**

Blood is a powerful image, with many associated meanings.

The human experience of blood – as a vital liquid circulating within the body – provide the basis for lay theories about a variety of illnesses. These illnesses are ascribed to changes in its volume, consistency, temperature, quality, or polluting power. (Helman, 1994, p. 32)

In some cultures, blood represents the life force, and having blood drawn can be traumatic. Many cultures have theories of disease, based on hot and cold elements and foods which affect the blood (Helman, 1994, p. 22). Blood can be used in language describing personality (hot-blooded, cold-blooded) and relationships (blood is thicker than water, bad blood, blood brothers). It is important to explain to patients that blood analysis is one of the primary diagnostic tools used in the hospital; some patients have routine blood work done every morning (if not more frequently) to monitor their response to treatment.

**Food and Hygiene**

“Most immigrant groups bring with them their own ‘dietary culture’ – their traditional beliefs and practices related to food” (Giger & Davidhizar, 2004, p. 52). Doctors may prescribe special diets while patients are hospitalized, particularly low sodium. Therefore, patients may not get to eat the food to which they are accustomed. In some cases, family may bring in their own food. However, that can be problematic: if the patient becomes ill from an outside food source, it is difficult to track the source of the bacteria. One issue that comes up frequently is nothing by mouth status. Family members
may find the patient’s complaint of thirst intolerable and insist on giving the patient water, when this may be contraindicated and may cause the patient harm (as in aspiration pneumonia and low serum sodium levels). In issues of patient care and bathing, nurses may experience conflicts with family members who insist on doing everything for the patient, such as bathing and feeding. But part of the plan for the patient’s recovery may be to encourage an increase in independence to maintain functional ability. Changing position, moving skeletal muscles, getting up and out of bed are important for expanding the lungs, preventing blood clots, and maintaining bowel function. Toilet habits are very personal, and people from the East may prefer water cleansing rather than the use of toilet paper (Kirkwood, 2005, p. 7). Giger and Davidhizar (2004) state,

Transcultural communication and understanding break down when caregivers project their own culturally specific values and behaviors onto the client. Each language has a whole set of unconscious assumptions about the world and life. (p. 27)

Lipson and Dibble (2005) promote the provision of culturally appropriate health care in 35 chapters, each one written by an “insider” of one particular cultural group. Topics include the aforementioned, religion, childbirth, family relationships, concepts of health and illness, and death rituals.

People have various beliefs about the transitions that accompany health, illness, birth, and death. Most of these beliefs are mediated by culture, age, and length of time in the U.S. Healthcare workers need a sensitive approach to cultural similarities as well as differences, and we need knowledge to inform our practice. This perspective can be summarized as ASK (awareness, sensitivity, and knowledge). Patients are the experts regarding their lives. When we approach a patient and ASK, our care can be more appropriate, no matter what group we are working with. (Lipson & Dibble, 2005, p. xii)

One obvious benefit of teaching English for healthcare to speakers of other languages would be to learn from the students how their healthcare systems and cultures
differ from the U.S. system. With each body system or area of care, the class could engage in a discussion about these differences, which will ultimately increase awareness and positively impact patient care. The best source of information on cultural practices and preferences are the patients themselves. Caring for many different types of patients and interacting with their families can be challenging and will require flexibility and sensitivity as to how culture shapes world view and one’s response to illness.

Conclusion

A review of the literature illustrates the complex task of sorting through the vast subject of AHE. The focus here is limited to three areas: ESP, linguistic elements of hospital communication, and aspects of culture related to illness and patient care.

ESP is a form of ESL designed for adults interested in a particular field. Content-based language instruction is an effective method to use for this type of course. The use of authentic materials and communicative tasks embedded in real workplace situations helps to make the language contextualized and meaningful. The intimate nature of the work of caring for the sick involves basic conversational skills and colloquial speech. The ability to communicate effectively in the hospital is the goal of instruction, and the classroom should equip learners with communicative tools they can use in the workplace. Learner motivation is a key ingredient in successful learning. Getting to know the students, making them feel comfortable, and striving to meet their wants and needs may help increase motivation.

The language of the hospital environment and the way it is communicated comprises the content to be taught. The language of medicine and science form the
foundation for the language of healthcare. Medical terminology is comprised mainly of Greek and Latin elements. Knowledge of the patterns in written forms of hospital communication and the language of description are necessary tools for healthcare work and documentation. The busy work environment demands the ability to code-switch back and forth between technical jargon and colloquial layperson’s language, and frequent use of abbreviations. American slang and idiomatic expressions can be problematic for non-native speakers, as well as the metaphors that shape our view of life, death, health, illness, the hospital environment and medicine.

Culture influences one’s response to illness and hospitalization. An awareness of culture and how it affects one’s experience in the hospital can facilitate more effective and therapeutic communication. Caring for the sick involves intimate contact with patients and interaction with their friends and family members. The best source of information on cultural practices and preferences is the patients themselves. The mutual sharing of language and culture in the second language classroom can enlighten those involved, and ultimately have a beneficial effect on patients and their care.

The next chapter provides an overview of the methods used to gather, organize, and attempt to synthesize the vast amount of information that exists within the topic of teaching English for the nursing profession.
CHAPTER III

METHODOLOGY

It is worth remembering that there is no such thing as an ideal book for all teachers and all situations.
(Jordan, English for Academic Purposes: A Guide and Resource for Teachers)

This chapter describes the development of this project. Although the bookstores are filled with books about nursing theory and practice, as well as pharmacology, anatomy, biology, nutrition, test reviews, flashcards, outlines, medical encyclopedias and dictionaries, somehow it was difficult to find specific texts on AHE for nurses. The author of this project drew on personal work experience as a bedside RN for 18 years. Prior to becoming an RN, her other work positions included nursing assistant, LVN, Unit Secretary, and phlebotomist in acute and long-term care settings. Nursing school, continuing education, seminars, and what is required for certifications such as CPR are all familiar subject areas. For the language component, the author is a native English speaker completing a degree in second language learning and teaching. This project attempts to merge these two areas—second language learning and teaching, and acute care bedside nursing—to create something of value for nursing students, nursing instructors, language students, and language instructors.
In a search of books for nurses, six medical English texts were identified. Only two of the books were designed specifically with nurses in mind. These do not use the terms “medical” or “medicine” in their titles: Arakelian, Bartram, and Magnall (2003) and Bradley (2004). The other four are directed mainly toward physicians and use those terms in their titles (Glendinning & Holmstrom, 2005; Maher, 1992; Pohl, 2002; Ribes & Ros, 2006). Only two use American-style English; the remaining four use British English. The two that emphasize American English, Maher (1992) and Ribes and Ros (2006), are designed for physicians. Each has its own particular audience in mind and seeks to meet their needs. They are all well-crafted and full of critical language and information. The authors deserve praise for their work, and the unique attributes and contributions of their books.

When choosing a textbook, Jordan (1997) recommends making a grid for comparison of several books (pp. 129-130). This is the basis for Table 1 (physical characteristics) and Table 2 (features). Table 3 highlights one or more desirable elements from each text to eventually incorporate into a textbook on American hospital English for nurses. Jordan (1997) also demonstrates how to create a textbook evaluation sheet, noting ease of use, adaptability and flexibility as desirable features (pp. 134). “Feedback from both teachers and students is considered essential if the material is to achieve its true purpose, that is, to help learners to learn effectively” (p. 138). It would be impossible to include everything needed in one book, but *Taber’s Cyclopedic Medical Dictionary* (Venes, 2005) comes close to achieving this goal. It is a dictionary and encyclopedia compiled by a team of professionals comprised of scientists, physicians and nurses,
among others. The terms are listed alphabetically, with phonetic spellings, notes on etymology, encyclopedic descriptions and illustrations, synonyms and cross references, and how terms relate to patient care. Listings of disorders are accompanied by etiology and symptoms. The whole book contains 700 illustrations and photographs, and 106 tables. A few of the many items in the appendices are Latin and Greek word roots, medical abbreviations, acronyms and symbols, weights and measures, lab values, information on nutrition and medical emergencies. There is also an interpreter in three languages (English, French and Spanish), and a listing of health care resource organizations in the U.S. and

<table>
<thead>
<tr>
<th>Feature</th>
<th>Arakelian, Bartram, &amp; Magnall</th>
<th>Glendinning &amp; Holmstrom</th>
<th>Maher</th>
<th>Pohl</th>
<th>Ribes &amp; Ros</th>
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<tbody>
<tr>
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<td>192</td>
<td>246</td>
<td>149</td>
<td>200</td>
<td>104</td>
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<tr>
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<td>7 3/4” x 9 7/8” x 5/8”</td>
<td>7 1/2” x 9 5/8” x 3/8”</td>
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<td>6” x 9 1/4” x 1/4”</td>
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<tr>
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<td>small magazine</td>
<td>half sheet, handy</td>
<td>half sheet, handy</td>
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<td>no</td>
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</tr>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Appendices</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>addresses of organizations</td>
<td>answers and word list</td>
</tr>
<tr>
<td>Feature</td>
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<td>Glenndinning &amp; Holmstrom</td>
<td>Maher</td>
<td>Pohl</td>
<td>Ribes &amp; Ros</td>
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</tr>
<tr>
<td>English style</td>
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<td>British, UK</td>
<td>American, int’l</td>
<td>British, UK</td>
<td>American</td>
</tr>
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<td>nurses in UK</td>
<td>healthcare instructors &amp; students in Australia</td>
<td>MDs in UK</td>
<td>MDs in U.S. &amp; int’l</td>
<td>MDs in U.S. &amp; int’l</td>
</tr>
<tr>
<td>Glossary</td>
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<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>woven throughout text</td>
</tr>
<tr>
<td>Dialogues</td>
<td>yes; written, some illustrated with cartoon drawings</td>
<td>yes; written dialogues and listening exercises with audio CD</td>
<td>yes; transcribed with audio CD (CD not available with my copy)</td>
<td>yes; doctor-patient interviews</td>
<td>no; but some good conversational phrases about healthcare issues</td>
</tr>
<tr>
<td>Illustrations</td>
<td>all cartoon drawings; some tables and graphs</td>
<td>drawings and cartoons; one photo of a nurse holding an infant, and a photo of a bowl of hummus</td>
<td>a few photos of people; mostly cartoons; copies of actual drug inserts, computer screens from research websites, medical documents</td>
<td>a few photos and drawings of surgical and medical equipment</td>
<td>drawings</td>
</tr>
<tr>
<td>Navigating</td>
<td>hard; busy</td>
<td>hard; busy</td>
<td>fair; topical chapters</td>
<td>easy; well-organized</td>
<td>fair; index helps</td>
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</table>

Canada. A special appendix (the final one) is devoted to nursing, containing a list of nursing organizations, nursing conceptual models and theories, and the NANDA
Table 3

Elements Useful in Developing Nursing ESL/ESP Materials

<table>
<thead>
<tr>
<th>Author</th>
<th>Author</th>
<th>Author</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arakelian, Bartram, &amp; Magnall</td>
<td>Glenndinning &amp; Holmstrom</td>
<td>Maher</td>
<td>Pohl</td>
</tr>
<tr>
<td>self-help workbook format</td>
<td>“colloquial language using parts of the body” (p. 33)</td>
<td>authentic documents, drug inserts, articles, examples from internet; photos of actual equipment, people</td>
<td>writing samples and templates; “understanding symptoms”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>all language exercises for practice and assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“grammar in use” section, using only authentic hospital situations, language, and sentences</td>
</tr>
</tbody>
</table>

approved nursing diagnoses. The whole book is small and compact, not too heavy (4 lb.), which is important because many tasks performed in the hospital are a strain on the wrists, hands, and upper arms. It is an excellent dictionary and reference tool. If only one book were to be recommended, this is it. In 1987, it was a required text for licensed vocational nursing programs. There is usually a *Taber’s* on every hospital unit. In the handbook, reference pages for *Taber’s* are listed to help students find information and illustrations to contextualize the written language.

Listed below are the six hospital English books, and a brief descriptive excerpt from each text.

1. *Hospital English: The Brilliant Learning Workbook for International Nurses* (Arekalian, Bartram, & Magnall, 2003). From the back cover:
Provides you with the information needed to improve your English communication skills and to develop confidence when treating patients, as well as arming you with some personal survival strategies so you can work, study and live without becoming overstressed.

From the forward by Martha Buchanan, Deputy President, Royal College of Nursing, Oxford: “This book will serve as a useful tool for mentors and supervisors of international nurses” (p. 10).

2. *English for Nursing and Health Care: A Course in General and Professional English* (Bradley, 2004). From the back cover:

Provides an entirely new approach to learning general and professional English needed in nursing related fields. It is designed to enable students . . . to relate the language they are learning to their own work experience.


To the student: the authors have cooperated closely with members of the medical profession in preparing this book to ensure authenticity. They have long experience in helping overseas medical personnel with their communicative needs. (p. 2)

4. *International Medical Communication* (Maher, 1992). From the back cover:

A unique reference manual designed to meet the needs of medical scientists, students and doctors around the world who do not speak English as a first language. This is not an exercise book, but a ‘do-it-yourself’ reference that guides the user through the various situations where effective communication is needed.

5. *Test Your Professional English: Medical* (Pohl, 2002). From the author:

To the student: Whatever your background, the tests in this book will help you improve your English. You can check your knowledge of key vocabulary and essential expressions and communicate more effectively and confidently in your work or in your studies. (v)
6. Medical English (Ribes & Ros, 2006). From the back cover:

This book is an introduction to the vast topic of medical English. It will not only help you to improve your English, but is also an introduction to the world of medical jargon.

In the preface, the authors state, “We recommend a thorough study of the unit ‘Grammar in Use,’ which was created using medical terminology, because without such practical grammar notions, we cannot build up our knowledge of English” (p. x).

A review of these books reveals that the emphasis is on the language that physicians use. British, as opposed to American usage, is the norm for these books about English for nursing. They present a type of broad overview of pre-nursing school material, conversational skills, some bedside skills, documentation, grammar, and personal coping strategies. The subject of nursing and the English required are too vast to have everything in one book; however, the same can be said of medicine. If the student has a background in the subject in another language, then he or she will be able to transfer knowledge in the primary language to the American context. If he or she has no background in healthcare, then fundamental English skills are necessary to even begin the educational prerequisites to get into healthcare courses. There is something relevant and helpful in each one of these books, but none of them has all the desired elements. Given unlimited time and resources, this handbook would become a very large textbook or series of textbooks. First, it would contain extensive illustrations, photographs, and diagrams. Taber’s has many photos and illustrations, and these are very helpful, hence, the listing of reference pages in the body systems chapter of the handbook. It would be nice to create a book with each chapter devoted to a body system, similar to a medical-surgical nursing textbook, but with an emphasis on ESP teaching of the material. It would be
helpful to perform an extensive linguistic analysis with word counts of all the material, to identify all the grammatical forms, vocabulary, and patterns of communication. This could be used to develop many lesson plans, with communicative tasks embedded in actual patient care and work situations. There would also be step-by-step instructions for certain procedures. Pohl’s (2002) book of word puzzles and exercises is inspiring; it would be a pleasure to build on her work to create a series of theme-based puzzle books, all specific to ESP for nursing. A series of videos, audio discs, and a companion on-line website would be great. This actual handbook consists of vocabulary and phrases and the initial content forming the foundation on which to build all these additional items.

Several important features of the handbook were drawn from the analysis of the six hospital English books. Table 1 describes the size and shape of the books. Attractiveness and ease of handling are important features. The handbook contained in this project will be magazine-sized, due to the dimensions of the format. An index, table of contents, and appendices help the reader locate information easily and quickly. This handbook does not have an index or appendices, but a published version would include those items. Table 2 notes the features of English style, audience, the presence or absence of a glossary, dialogues and illustrations. This handbook is intended for ESP students, ESP instructors, nursing students, and nursing instructors. The style of English usage is American. A separate glossary, as opposed to one woven throughout the text, is important for locating terms quickly and easily. Ideally, a handbook of the type presented here would include dialogues of real-life and workplace situations, with accompanying recordings, so that students can read and listen to them. Ease of navigation and an attractive, consistent, clear organization help to make the reading experience a pleasant one.
The handbook in this project is in a preliminary format. Table 3 describes elements which stand out in each of the six medical English texts. A self-help workbook style is helpful for nurses and others who feel stressed in work and/or school (Arakelian, et al., 2003). Colloquial language is important for communicating with co-workers and patients (Bradley, 2004). Authentic documents and other realia embed the language in real-life contexts, and familiarize students with materials they will use professionally (Glendinning & Holmstrom, 2005). Writing samples and templates for correspondence and other documents are helpful for reading and writing practice in the target language (Maher, 1992). Medical transcription templates are offered in Chapter 6 of the handbook. Language puzzles and cloze and matching exercises incorporating medical language are an enjoyable way to review the material (Pohl, 2002). A published version of this handbook would contain many puzzles and exercises modeled after Pohl’s (2002) book. Grammatical forms that appear frequently in the context of hospital documents and conversation (Ribes & Ros, 2006), can be used in exercises and examples taken from real-life situations. A published version of the handbook would include these also.

Topics important for nurses are basic English conversational skills, American-style English usage, descriptive terms, and dialogues and grammar points embedded in authentic language situations from the hospital context. Basic nursing educational topics include interpersonal communication and sociology, nutrition, anatomy and physiology, pharmacology, assessment and monitoring, interpretation of lab values, documenting care, interpreting physicians’ notes, medical terminology, and working with hospital equipment. An overview of nursing educational program requirements would also help to prepare students who wish to apply for nursing programs in the U.S.
This handbook addresses the language nurses use in U.S. hospitals. Its purpose is to introduce the subject of hospital English for nurses, and to assist instructors and students in finding relevant and helpful links to the subject matter for further development. It can be used as a nursing reference in the hospital, and also as the foundation for a course in ESP for nurses and other healthcare workers. A section entitled *Preparing for Instruction* is included to assist in designing lesson plans.

Language instructors will be familiar with the process of teaching ESL, but perhaps not this particular content. Nursing instructors will be comfortable with the language, but perhaps less experienced with language teaching. Students in ESP classes and nursing programs, and others reading this work may have different backgrounds, such as healthcare, linguistics, or some other field of work or study. They may even be teachers themselves. This portion includes information about content standards, curriculum frameworks, instructional objectives, an effective instructional sequence, multiple intelligences, and a lesson plan template. This may be new for some, and a review for others.

Colloquial expressions are important in facilitating communication. Bradley (2004) has great examples of dialogues and casual conversations between nurses and patients. Most of the conversation and interactions in the hospital are informal, using colloquial expressions and slang. Nurses can benefit from exposure to and practice in casual conversation. The handbook offers some sample greetings and expressions for initial patient contact and assessment, as this can be a tense moment for nurses, meeting the patient for the first time.

Maher (1992) devotes a chapter to “understanding symptoms” with expressions patients use to describe their symptoms. Each patient communicates in a unique
way. People describe symptoms using many different expressions. Even people from the same community may have different ways of describing the same thing. The handbook includes translations of medical jargon into lay terms and also some sample expressions patients may use, such as “wiped out” to describe fatigue.

Two of the texts have tables of weights and measures. Bradley’s (2004) use of units such as “tonne” and “hectare” is intriguing, as these are not used by nurses in U.S. acute care settings. Nurses are required to measure things and calculate drug dosages often. The handbook includes a table of weights and measures most commonly used, and also some dosage calculation formulas for quick reference. Excluding items not used helps consolidate the material and reduce stress.

Four of the books are written for a British audience. Maher (1992) addresses British and American spelling differences (pp. 77-78). There are hospital terms in the British texts which are not used in the U.S., and these may confuse patients, such as “operating theatre” to describe the operating room, and referring to nurses as “sisters.” And the unit *stone* is not used in the U.S. to measure human weight.

**Design Criteria**

A handbook such as this should strive to meet state and national educational standards for language instruction. There are many existing evaluation tools and guidelines that can be used to assess progress toward those standards. One option is a list of questions from the *Textbook Evaluation Checklist* (adapted from Robinett, 1978, pp. 249-251):
1. Will this textbook help to accomplish the goals of the course?

2. Does the book fit the background of the students?

3. Does the book’s theoretical approach reflect the philosophy of the institution?

4. Does the book integrate the four skills of listening, speaking, reading, and writing?

5. Does the book reflect what is known about language and language learning?

6. How would you assess the quality of the practice material?

7. How is the book sequenced?

8. Is the vocabulary relevant and effectively presented?

9. Is it American, British, or International-style English dialect? Is there a cultural bias?

10. Is the format attractive, usable, and durable?

11. Are there any accompanying materials?

12. Is there a teacher’s guide, and is it helpful?

Another set of guidelines comes from the California State Department of Education’s English as a Second Language (ESL) Handbook for Adult Education Instructors (1990). For instruction, a communicative/functional approach is advised for students to achieve communication in real-life, personal situations. To make the input comprehensible, teachers can use props, body language, visuals, and situational contexts (p. 10). For lesson plans, teachers can begin with a warm-up session in which terms from previous lessons are reviewed, then model the new material (p. 12). In teachers’ manuals and reference materials there should be an overview or summary for each unit, including goals and objectives clearly stated in communication terms, and examples of creative
language application activities. Suggestions are provided for teaching students of varying abilities and for presenting the material through individual as well as group activities. Exemplary instruction is student-centered, features communicative activity, and provides for language comprehension before production is required. A variety of activities, well-paced throughout instruction time, present the target language through content in realistic contexts (p. 42).

The California State Department of Education’s (2003) Foreign Language Framework for California Public Schools Kindergarten through Grade Twelve provides insights and guidance on how to meet state and national standards, and create optimal instructional materials for students. Though written for K-12 programs, elements of this framework can be applied to the adult ESL classroom. One starting point in evaluating materials and methods is to “identify student outcomes on which to focus the entire program, units of instruction, and individual lessons” (p. 27). According to this document, “materials must be fully aligned with the content of the framework” (p. 57). Frequent assessments must be conducted to verify that students are moving toward intended outcomes.

The successful implementation of instruction can be measured by the assessment of students’ progress and the evaluation of program effectiveness. It is important that assessment efforts reflect coherence between the teachers’, the school’s, and the district’s instructional goals. (p. 37)

The organization known as TESOL (Teaching English to Speakers of Other Languages, Inc.) has formulated Standards for Adult Education Programs (2002). “The standards can be used to review an existing program or as a guide in setting up a new ESOL program” (www.tesol.org). Within part four of this document is a “program self-
review instrument,” available on-line, which is another option for evaluating instructional materials, techniques, and class design. Within it nine areas are described: program structure, curriculum and instructional materials, instruction, learner recruitment, learner retention, assessment, employment conditions, professional development, and support services. Each area has a list of “measures” in a left column, and space in a right column for “sample evidence” that the measure has been met. For example, under Area 3A: Instruction, one measure states “instructional activities resemble activities in the learners’ lives or prepare learners for relevant use of the language” (p. 81). Then the right column provides space for evidence such as lesson plans, interviews with learners, and evaluations of instructors.

It is important to meet with peers regularly to ensure the best outcomes and most effective instruction. After obtaining the current curriculum frameworks and educational standards that are relevant to the particular instructional context, systematically compare the materials against all the criteria, and ask peers to also review materials. Also to be considered are educational standards for nursing programs which are developed by individual state boards. Ways to improve professional practice include keeping up with current research, attending seminars and workshops, and seeking feedback from peers as well as students.

Handbook Organizational Framework

The handbook consists of ten chapters. A brief introduction to each chapter describes the chapter’s contents, some language forms and functions found in the particular area, some possibilities for classroom activities and instruction, and ideas for mate-
A section entitled Preparing for Instruction precedes the ten chapters.

Preventing for Instruction

This section contains an introduction to and brief description of educational content standards, curriculum frameworks, Mager’s (1962) instructional objectives, an Effective Instructional Sequence (CDE, 1985), Gardner’s (1983) theory of Multiple Intelligences, and a personally-designed lesson plan template.

Rationale

This information is intended to assist instructors in meeting state and national standards for instruction in English as a Second Language and Foreign Languages. Templates for task design and lesson plans can help organize the material, and instructors can employ various methods and techniques to teach the content. Formulating behavioral objectives will help to effectively assess student learning.

Chapter 1: Body Systems

This chapter contains a list of seven body systems.

Contents


2. Within each category, there is a sample “normal” nursing assessment.

3. Sample greetings and expressions for initial patient contact and assessment.


5. Names of disorders and conditions.
6. Translations of conditions and procedures into lay terms.

7. Reference page numbers for definitions, visuals, and discussion.

8. The language of nursing assessment, documentation, care plans, and patient teaching.

Rationale

Nurses assess patients and document their findings. The standard order or format for documenting a patient assessment is “head-to-toe,” and verbal reports of patient status often follow this pattern also. Information about a patient’s physical condition is often organized by body systems. As in any new relationship, meeting the patient for the first time can be a tense moment for nurses, so examples of greetings and some of the language used during the assessment process are offered. Bradley (2004) has great examples of dialogues and casual conversation between nurses and patients. Colloquial expressions are important to facilitate communication, and to help explain things to patients and their families. Nurses must interpret writings that use medical terminology and help translate these terms so that patients can understand them. Assessment, documentation, developing care plans, and patient teaching are integral parts of nursing programs and clinical care.

Chapter 2: Patient Care

This chapter includes language related to patient care situations.

Contents

1. Conversational language and colloquial translations of medical terms and phrases.
2. Activities of daily living (ADLs), which include exercise, eating, and bathing.


4. Terms used to describe intravenous sites and devices.

5. Expressions for describing pain and feelings.

6. Reference pages in the *Oxford Picture Dictionary* and *Taber’s* for definitions, visual aids, and discussion.

**Rationale**

Each patient communicates in a unique way. People describe symptoms using many different expressions. Even people from the same community may have different ways of describing the same thing. Maher (1992) devotes a chapter to “understanding symptoms” with the expressions patients use to describe their symptoms. Pain assessments are an important part of nursing work. There are hospital terms in the British texts which are not used in the U.S., and these may confuse patients here. Maher (1992) addresses British and American spelling differences (pp. 77-78). A patient’s daily routines can be very personal, and having to describe them (as well as engage in routines in the presence of another person) may induce fear or anxiety. Nurses can benefit from exposure to and practice in casual conversation. Assessment and care of intravenous sites and devices is a nursing responsibility.

**Chapter 3: Weights and Measures**

This chapter is on weights, measures, and dosage calculations specific to nursing.
Rationale

Nurses are required to measure things and calculate drug dosages often. Before administering any medication or intravenous fluid, the nurse must check that the dosage and concentration matches the physician’s order. Some medication dosages are calculated according to a patient’s weight. Two of the six texts reviewed include tables of weights and measures. This is critical information related to medication administration.

Excluding items not used helps consolidate the material and reduce stress. The metric system is used in documentation, but occasionally American units are incorporated, such as a tablespoon or ounce, and feet and inches for height.

Chapter 4: Glossary of Terms

This chapter is a list of abbreviations and acronyms specific to the hospital setting.

Contents

1. Two hundred forty-six terms that are frequently spoken, heard, read or written in the course of work.

2. Alphabetical listing.
3. Some cross-references.

4. Most frequently used terms in acute care settings.

Rationale

A glossary of terms is a critical component of hospital work and language. Nurses continually encounter unfamiliar words and abbreviations in medical records and physicians’ orders. Alphabetizing lists is essential for finding information quickly. Each of the six texts reviewed contains a glossary of terms.

Chapter 5: Basic Life Support Lesson Plan

This chapter is a basic life support (BLS) lesson plan designed for English language learners.

Contents

1. The language of a Cardiopulmonary Resuscitation (CPR) class.

2. Elements of the lesson plan are a listing of goals, language functions, objectives, possible materials to use, vocabulary and grammar.

3. Format following an Effective Instructional Sequence (EIS).

4. The A-B-C-D sequence of CPR.

5. Sample communicative task using a transcript of a 911 call.

6. Sample multiple choice exam questions.

Rationale

CPR certification is a requirement for nurses. This lesson serves as a model for the types of classes nurses and other healthcare workers will be attending, and an introduction to the type of language encountered in those classes. A sample lesson plan
incorporating an Effective Instructional Sequence (EIS) pattern, a communicative task, and multiple choice questions serves as a model for instructors as well as students, and embeds the language in a real-life situation. The A-B-C-D sequence of CPR is an example of the language of sequence, and also a real-life skill.

Chapter 6: Medical Transcription Templates

This chapter contains an outline of common medical transcription templates.

Contents

1. Sample document formats that hold key information.

2. Outlines for a history and physical, radiology report, operative report, physician’s progress note, and a patient discharge summary.

3. A listing of items with brief narrative phrases.

Rationale

This material will expose nurses to the types of documents and writing style involved in healthcare. Nurses can practice finding relevant patient information.

Chapter 7: Nursing Diagnosis

This chapter describes the language of nursing diagnoses and the nursing process.

Contents

1. An introduction to the North American Nursing Diagnosis Association (NANDA) taxonomy.

2. (P_E_S_) format: problem, etiology, signs and symptoms.

4. A list of helpful websites.

Rationale

This material addresses language used in nursing programs and patient care plans. Nurses will be required to develop and edit nursing care plans in nursing school and in the clinical setting. Questions about care plans may appear on the NCLEX exam. This language can be confusing, even for native English speakers, so it warrants some exposure and practice.

Chapter 8: HIPAA, Patient Rights, and DPAHC

This chapter addresses patient privacy laws, patient rights, and designation of a power of attorney for healthcare.

Contents

1. A brief description of the Health Insurance Portability and Accountability Act (HIPAA) laws.

2. A list of patient rights from the American Hospital Association

3. A brief definition of a Durable Power of Attorney for Health Care (DPAHC).

4. It presents the language of policies and procedures and some legalese.

Rationale

This type of writing is frequently encountered in healthcare situations. Nurses are required to adhere to their particular institution’s policies and procedures in the delivery of patient care. Nurses must inquire about patients’ DPAHC status and may have to
explain what it is. Nurses also function as patient advocates. Questions related to these topics may appear on the NCLEX exam.

Chapter 9: Recommended Books and Websites

This chapter is a list of recommended books and websites.

Contents

1. A list of 20 books and ten websites that the author personally finds helpful.

Rationale

It is hoped that this list will help students and instructors to find relevant references and links for further study.

Chapter 10: Reader Questionnaire

Contents

This chapter contains a reader questionnaire.

Rationale

The questionnaire is intended to assist in improving and expanding on this handbook. As previously mentioned, one aim of this project is to open a dialogue on this topic and encourage others to contribute and develop related materials.

This handbook contains examples of the language nurses will use in the hospital. This is the type of content taught in an ESP course. This project was created from background knowledge, professional work experience, research and study, intuition and personal preferences.
The author recommends adapting existing medical and nursing textbooks for instruction, while also incorporating elements of the Test of English as a Foreign Language and the National Council Licensure Examination for nurses, utilizing a team approach with an insider from each discipline.
CHAPTER IV

DISCUSSION

Summary

This project investigated the topic of AHE, specifically for nurses. Writings on the subject of ESP, the language used in the hospital, and culture as it relates to patient care have been reviewed. It describes some of the realities of American hospital work, and attempts to create a practical tool to use in conjunction with *Taber’s Cyclopedic Medical Dictionary* in the clinical setting, as well as with *The Oxford Picture Dictionary* in the classroom setting. Supplemental materials include a lesson plan utilizing elements from an authentic CPR course, and an outline of the language used in writing nursing diagnoses, something nursing students will need to know.

This project has proved to be a tremendous undertaking. A greater respect has been gained for the complexities inherent in the task of curriculum development. It is difficult to organize all the material, and make decisions as to what is essential, and what can be excluded. It is helpful to look at the project from several perspectives, such as that of language teacher, ESP student, nursing instructor, and nursing student. An adjunct course for ESL/ESP students could be created to assist non-native English speakers as they study the health sciences or enroll in vocational programs. Feedback is needed from students and instructors. Collaboration with peers is necessary to improve the material and create an effective language instruction tool.
The review of books about hospital English has been enlightening and inspiring. Their many similarities are intriguing, yet each one is unique. The book that is most courageous and comes closest to a nursing/ESP text is Bradley (2004). Although geared toward an Australian and international audience, it resembles a traditional language text, with thematic chapters and language embedded in clinical contexts.

Reading current research in the field has helped to structure the writing and will prove helpful in conducting and publishing any future research. Professional development demands keeping up with current research by attending seminars and workshops, and also by studying second language instructional theories and techniques. Engaging in personal reflection and being open to feedback from peers and students will assist in improving professional practice. The ultimate goal is to create something that will meet the needs and wants of the learners.

Conclusions

Adult professionals are very busy with their work and personal lives. General English courses may be too broad and not as applicable to real-life situations as ESP. Though bookstores are filled with various medical and nursing texts, there is a lack of specific materials for nursing ESP instruction. Students transfer what they already know and do in one language to the same situations in English. ESP formats, compared to more traditional and general ESL courses, may be more interesting and beneficial to meet an immediate need. The hospital can be a very fast-paced and stressful environment. To communicate directly with patients and staff requires colloquial and conversational English skills, as well as the ability to translate medical and scientific jargon into lay terms.
and to adapt to unique communication situations. This material offers some practical
information that facilitates more effective communication in the workplace. It can also
support development of instructional materials and/or courses for non-native English-
speakers seeking jobs in the U.S. healthcare system. The content of this project and the
language described merit further exploration and expansion due to the complexities of
this specific linguistic setting, and the multi-dimensional work that caring for the sick
entails.

Recommendations

*It (ESP) needs to heed the repeated calls to establish its empirical validity as a viable means of second language
acquisition. There is also a dire need for research in the occupational and sociocultural aspects of ESP as well as
the training of ESP practitioners.* (Master, Research in English for Specific Purposes, in Handbook of Research in Second
Language Teaching and Learning)

There is a need for developing all types of American-style (as opposed to Brit-
ish) ESP materials for work in American hospitals. The language spoken in U.S. hospitals
is predominantly American English. People in the U.S. are living longer, and as a result,
there will be more job opportunities in healthcare. Patient care is holistic and multi-
faceted. The language of patient care and the hospital setting is complicated, due to the
context of many personalities interacting amid stressful situations.

ESP materials designed specifically for American hospital work can help pre-
pare students for healthcare educational programs as well as the clinical environment.
Needs assessment tools, introductory language courses to prepare for hospital work and
study, and analysis and instruction on the types of exams required for certification and licensing would all be helpful.

Suggestions for Instructors

Those who are reading this may be ESL teachers, nursing instructors, or adult education instructors in vocational programs, with English being their first or second language. Whatever the field of expertise, instructors have a lot of knowledge to share and much to contribute in the development of instructional materials and classroom techniques. Materials geared toward the specific needs of SLLs interested in healthcare occupations in the U.S., such as introductory or preparatory ESL courses for the health sciences, could be created by those with various areas of specialty and experience. There are many different types of job opportunities in the hospital, and non-native speakers may wish to enter vocational programs for positions such as respiratory therapist, pharmacy technician, radiological technician, among others, in addition to or instead of nursing. Those with extensive education and training in a language other than English may have to repeat basic health science classes again in the U.S. The development of ESL lesson plans based on body systems and anatomy and physiology, for example, will be helpful for students studying these subjects. The lessons will reinforce language that they may be using at work. The creation of workbooks with photographs of actual hospital equipment, copies of authentic documents, and transcripts of authentic conversations from the workplace would be helpful. It is always best to simulate the actual workplace as authentically as possible, and use authentic materials to embed the language in a real context. However, it is necessary to abide by all HIPAA rules and regulations and copyright laws, and obtain prior permission before using any documents or copyrighted images. A colloquial
English phrase book with material from multiple contributors, incorporating hospital language, would be a handy resource and good material for the classroom. The development of ESL lesson plans based on and adapted from sample NCLEX-RN exam questions will help to prepare students for nursing programs; foreign nurses will have to take the test in order to work in the U.S.

Hopefully this project has provided some new information and encouraged others to engage in independent research and development of materials.

Suggestions for Students

Students reading this work may have many different backgrounds. They may be licensed healthcare professionals in a country other than the U.S., with extensive English language knowledge, or none. So whether healthcare work and English are familiar areas, or new, there may be various educational requirements needed in order to enter a chosen field in the U.S. One area to focus on is what is needed to complete general education requirements in the U.S., for example, the TOEFL (Test of English as a Foreign Language). General education foundation courses will be required to apply for nursing school in the U.S.

The subjects of anatomy and physiology, interpersonal communication, nutrition, general chemistry, basic math, and microbiology are part of nursing preparation. If these subjects have already been studied in a language other than English, a review of some of the American textbooks will facilitate learning to communicate this knowledge via English. Some ESP students have noted that classroom lectures in English can be difficult to understand, due to digressions and classroom discussions during the lecture, in addition to the use of slang and personal anecdotes. The practice of listening to lectures
and taking notes can help prepare for the classroom; some lectures may be found on-line. Entry-level positions in healthcare facilities may help to reduce anxiety in the particular work environment, while at the same time providing exposure to the language. Medical terminology is a required foundation course for the healthcare professions, and taking a medical terminology class is strongly recommended. Medical terminology textbooks can be found in bookstores or libraries for independent study as well. The NCLEX is the nurse licensing exam in the U.S. An NCLEX exam review book will provide exposure to the material and the licensing test format.

A medical-surgical nursing textbook and/or a textbook of any other healthcare subject of interest can offer a good introduction to the material.

At this point, it would probably be most efficient to adapt current nursing textbooks for ESP teaching purposes, and use this handbook as a supplement. The subject is vast, and nursing textbooks contain all the required elements to prepare students for the hospital, as well as for school. But the text can be dense, and the volume of the material may be overwhelming at first. Individual chapters can be dissected and used in designing lessons. And a nursing textbook is an example of authentic instructional material. This handbook is a starting point from which to advance to further research, materials development, and ultimately an ESP course design. This material would best be taught by an insider who is accustomed to communicating via the specialized language. But knowledge of ESL teaching and learning is essential also, so perhaps a team approach to teaching American Hospital English would be most effective.
REFERENCES


APPENDIX A
# Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>81</td>
</tr>
<tr>
<td>Preparing for Instruction</td>
<td>82</td>
</tr>
<tr>
<td>Chapter 1: Body Systems</td>
<td>87</td>
</tr>
<tr>
<td>Chapter 2: Patient Care</td>
<td>103</td>
</tr>
<tr>
<td>Chapter 3: Weights and Measures</td>
<td>109</td>
</tr>
<tr>
<td>Chapter 4: Glossary of Terms</td>
<td>111</td>
</tr>
<tr>
<td>Chapter 5: Basic Life Support (BLS) Lesson Plan</td>
<td>117</td>
</tr>
<tr>
<td>Chapter 6: Medical Transcription Templates</td>
<td>126</td>
</tr>
<tr>
<td>Chapter 7: Nursing Diagnosis</td>
<td>128</td>
</tr>
<tr>
<td>Chapter 8: HIPAA, Patient Rights, and DPAHC</td>
<td>130</td>
</tr>
<tr>
<td>Chapter 9: Recommended Books and Websites</td>
<td>133</td>
</tr>
<tr>
<td>Chapter 10: Reader Questionnaire</td>
<td>135</td>
</tr>
</tbody>
</table>
**Introduction**

This handbook addresses the language nurses use in U.S. hospitals. Its purpose is to introduce the subject of hospital English for nurses, and to assist instructors and students in finding relevant and helpful links to the subject matter for further development. It can be used as a nursing reference in the hospital, and as the foundation for a course in English for Specific Purposes (ESP) for nurses and other healthcare workers. If you are a language instructor, it contains some of the key content to be taught. If you are a nursing instructor, it identifies key language for non-native speakers of English, and offers suggestions for instruction. If you are a student, you will find common phrases, abbreviations, and references essential in the clinical setting.

A section entitled *Preparing for Instruction* contains information to assist in designing lesson plans. As language instructors, you will be familiar with the process of teaching ESL, but not this particular content. As nursing instructors, you will be comfortable with the language, but perhaps less experienced with language teaching. As learners, you come from different backgrounds, perhaps healthcare, linguistics, or some other field of work or study; you may even be teachers. This portion includes information about content standards, curriculum frameworks, instructional objectives, an effective instructional sequence, multiple intelligences, and a lesson plan template. This may be new for some, and a review for others.


The following is not intended to be exhaustive; it is a preliminary collection of material to be used as a resource for working, studying, and teaching.
Preparing for Instruction

Standards

Generally speaking, a standard can be defined as “something established by authority, custom, or general consent as a model or example; criterion. Something set up and established by authority as a rule for the measure of quantity, weight, extent, value or quality” (Mish, 1996, p. 1145). One starting point in the process of designing and planning language instruction is with educational content standards. On its website, the California State Department of Education states that “content standards were designed to encourage the highest achievement of every student, by defining the knowledge, concepts, and skills that students should acquire at each grade level” (www.cde.ca.gov). Within the realm of language learning and teaching, the National Standards in Foreign Language Education Project (NSFLEP) has produced Standards for Foreign Language Learning: Preparing for the 21st Century (1996). Although developed with K-12 students in mind, many aspects of these standards are applicable to the adult English language classroom. They are “intended to serve as a gauge for excellence, as states and local districts carry out their responsibilities for curriculum in the schools” (p. 13). “Ideally, students need to be able to use the target language for real communication, that is, to carry out a complex interactive process that involves speaking and understanding what others say in the target language, as well as reading and interpreting written materials” (NSFLEP, 1996, p. 21). One goal that is emphasized is that of communicative competence: “knowing how, when, and why, to say what to whom” (NSFLEP, 1996, p. 11).

TESOL has developed the Standards for ESL/EFL Teachers of Adults Framework (2008). The eight standards are organized within eight “domains”: planning, instructing, assessing, identity and context, language proficiency, learning, content, and commitment and professionalism. Each standard describes a teacher behavior. For example, within the domain of content, standard seven states that, “teachers understand that language learning is most likely to occur when learners are trying to use the language for genuine communicative purposes” (www.tesol.org).

These and other Standards provide targets for effective language instruction, to ultimately promote communicative competence in the learners. For more information regarding educational content standards, see:

www.actfl.org
www.adultedcontentstandards.ed.gov/

Frameworks

Another important tool in the work of curriculum design is the use of educational curriculum frameworks. The term framework can be defined as “a basic conceptual structure (as of ideas), or “a skeletal, openwork, or structural frame” (Mish, 1996, p. 463). The
California State Department of Education states on its website that “Frameworks are blueprints for implementing the content standards adopted by the California State Board of Education and are developed by the Curriculum Development and Supplementary Materials Commission” (www.cde.ca.gov/be/st/fr/). One example is the California State Board of Education’s *Foreign Language Framework for California Public Schools Kindergarten Through Grade Twelve* (2003). Even though this framework also is aimed at K-12 learners, many of its elements are applicable to the adult ESL classroom. In eight chapters, the Framework addresses such topics as proficiency levels, content of a foreign language curriculum, instruction and assessment, and criteria for evaluating instructional materials. Chapter Three discusses the effective use of language, and three essential components of developing literacy in a foreign language: *function* (a linguistic task performed with the language, such as asking for and responding to information, or describing events), *content* (the topic used as the focus of instruction), and *context* (the setting in which the language is used). These are important elements to consider when designing and planning for instruction (p. 18).

This and other frameworks offer guidelines for structuring class time and designing effective programs. Individual state boards of education each have their own frameworks.

**Objectives**

An *objective* can be defined as, “Something toward which effort is directed: an aim, goal, or end of action; intention (Mish, 1996, p. 801). An *instructional objective* describes an intended outcome. An excellent resource on the topic of objectives is *Preparing Instructional Objectives* by Robert F. Mager (1962). The following material is adapted from his book.

“When clearly defined goals are lacking, it is impossible to evaluate a course or program efficiently, and there is no sound basis for selecting appropriate materials, content, or instructional methods” (Mager, 1962). *Behavioral* objectives help to clarify what it is you want to teach, and how you will know when students have learned it. The behavior demonstrated by the learner is the observable act that functions as evidence that the learner has achieved the objective. So the behavior must be determined and described in advance.

Mager (1962) offers guidelines for writing clear and unequivocal instructional objectives:

1. Identify and name the specific, over-all behavior act (e.g., “to list the names of 5 bones in the human body”).
2. Define important conditions in which behavior will occur, specify time limit (e.g., “given a pencil and paper, and within 5 minutes”).
3. Define criterion of acceptable performance (e.g., “3 of the 5 names will be spelled correctly”).
4. Write a separate statement for each objective.
One informative website on this topic is from the University of Florida’s College of Medicine: www.med.fsu.edu/education/FacultyDevelopment/objectives.asp

Clear and unambiguous behavioral objectives are part of evaluating and assessing the effectiveness of language and content instruction. As will be addressed in the next section, evaluation and assessment are part of an effective instructional sequence.

An Effective Instructional Sequence

A Handbook for Planning an Effective Foreign Language Program (1985) was developed by the California Department of Education and is widely used in teacher development workshops offered through the California Foreign Language Project. The following five phases of an Effective Instructional Sequence (EIS) are outlined, with suggestions for teaching and learning activities for each phase of the sequence (pp. 14-29).

An Effective Instructional Sequence (EIS)

1. Setting the stage: statement of the learning objective, motivation of students and tapping into prior knowledge. Define clear lesson objectives; capture students’ interest.
2. Comprehensible Input: presentation of new material. Use a variety of language models, realia (authentic materials); make visually rich presentations and check comprehension frequently.
3. Guided Practice: activities that help students to internalize new material. Use realistic, relevant, and interesting language; provide contextualized and meaningful activities.
4. Evaluation: tools we use to demonstrate students’ knowledge and proficiency. Make sure the evaluation techniques match objectives; move on if students meet expectations.
5. Application and Extension: activities in which students use what they have learned to generate their own language. Make sure students are made aware of the extent of their progress after each lesson. Use tasks for communication practice that focus on meaning. (More recent versions reverse the order of the last two stages).

An effective instructional sequence helps organize instruction and facilitate learning.

Multiple Intelligences

A more recent view of human intelligence and the capacity to learn can be found in Howard Gardner’s (1983) theory of multiple intelligences. Gardner “maintains that all humans possess at least eight different intelligences that represent a variety of ways to learn and demonstrate understanding” (Christison, 1990, p. 1). According to this theory, everyone possesses all eight intelligences (or more), but each person has some intelligences that are more or less pronounced or developed than others. One person may claim that he or she is “tone deaf,” another may struggle with math and numbers, and a third
may feel clumsy and not good at sports. Then there are other people who may excel in these areas. Howard Gardner (1999) defines an *intelligence* as “a biopsychological potential to process information that can be activated in a cultural setting to solve problems or create products that are of value in a culture” (pp. 33-34). He also claims that “intelligences arise from the combination of a person’s genetic heritage and life conditions in a given culture and era” (p. 45).

**Howard Gardner’s original list of eight intelligences** (from Christison, 1990, p. 1):

1. verbal/linguistic
2. logical/mathematical
3. visual-spatial
4. bodily/kinesthetic
5. musical/rhythmic
6. naturalist
7. interpersonal
8. intrapersonal

These intelligences can also be described using the term “smart,” e.g., word smart, logic smart, picture smart, body smart, music smart, outdoor smart, people smart, self smart. Traditional classroom lecture formats and assessment techniques seem to emphasize verbal/linguistic and logical/mathematical capacities while focusing little, if any, attention on other areas. When a topic is chosen for a lesson, look at it from all eight perspectives, and attempt to incorporate an instructional method that would appeal to several, if not all, of the intelligences in order to give all learners an equal opportunity to access the material. A variety of activities will allow students the opportunity to learn and to demonstrate their learning via different methods. Some suggestions for varying modes of instruction are narration to appeal to the verbal/linguistic capacity, an aesthetic exercise for the visual/spatial intelligence, and a hands-on project for bodily/kinesthetic.

“When teachers are able to use different pedagogical approaches, they can reach more students in more effective ways” (Gardner, 1999, p. 168). Incorporating a multiple intelligences approach to lesson plans will appeal to a broad range of strengths and capacities in the learners.

In summary, when planning instruction:

1. Consider the needs and backgrounds of the learners.
2. Design communicative activities.
3. Review and incorporate the ESL standards.
4. Review and incorporate goals of relevant frameworks.
5. Clearly state behavioral objectives.
6. Incorporate elements of Multiple Intelligences theory to appeal to varied learning styles.
7. Follow an Effective Instructional Sequence pattern.
8. Vary the types of instruction and activities.
9. Provide ample use of visuals, manipulatives (hands-on materials), and realia (authentic materials).

Here is my version of a lesson planning template (condensed to save space):

<table>
<thead>
<tr>
<th>Lesson Plan Template</th>
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<tbody>
<tr>
<td>Learners (level, needs):</td>
</tr>
<tr>
<td>Topic:</td>
</tr>
<tr>
<td>Objectives/goals (what the students will know and be able to do):</td>
</tr>
<tr>
<td>“By the end of this lesson, learners will be able to” (measurable, observable behavior):</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>etc.</td>
</tr>
<tr>
<td>Language forms:</td>
</tr>
<tr>
<td>Language functions: (specific language-based tasks normally performed in the course of daily life, e.g., asking, describing, reading for information).</td>
</tr>
<tr>
<td>(Identify grammar, structures):</td>
</tr>
<tr>
<td>(Identify task(s) performed):</td>
</tr>
<tr>
<td>Targeted Standards (ESL, TESOL, etc.):</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>etc.</td>
</tr>
</tbody>
</table>
Targeted intelligences:
1. (verbal/linguistic; word smart):
2. (logical/mathematical; logic smart):
3. (visual-spatial; picture smart):
4. (bodily/kinesthetic; body smart):
5. (musical/rhythmic; music smart):
6. (naturalist; outdoor smart):
7. (interpersonal; people smart):
8. (intrapersonal; self smart):

Materials: types, amounts:

Effective Instructional Sequence (EIS):
1. Setting the Stage:
2. Comprehensible Input:
3. Guided practice:
4. Application and Extension:
5. Evaluation

Cultural aspects:

**Chapter 1: Body Systems**

This section contains a list of seven body systems: neurological, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, and integumentary. Within each category, there is a sample “normal” nursing assessment and an example of common greetings, questions and commands used during the assessment process. The standard order or format for documenting a patient assessment is “head-to-toe.” The most efficient verbal report (when one nurse transfers care of the patient to another nurse, and discusses the patient’s status), will also follow this pattern, although nurses may skip around among many different topics as they talk while giving the report, and remember certain information they wish to convey. Also, small talk and brief conversations unrelated to the task at hand often occur at this time. There can be many verb tenses in one verbal report, e.g., he has a rash; he didn’t eat much today; he will be going to CT tomorrow. Most charting is computerized now, but it is good practice to write out an assessment in narrative style. Some word roots, common conditions, colloquial translations of terms, and reference pages are also included.

**Teachers:** The language forms and functions in this category include, but are not limited to, greetings, commands, lay terms, slang, and passives; the language of assessment, documentation, and report; describing, explaining, asking, clarifying, and summarizing. Some possibilities for classroom activities and instruction include practice greeting and
assessing patients, role-plays, practice documenting findings, practice giving and receiving report, listening for key information, clarifying meaning. Suggested classroom materials include illustrations and posters of relevant anatomy, physiology, medical terminology, lists, and task sequences, photos from magazines, color, shape, and descriptive term charts. Flashcards, dictionaries, encyclopedias, medical and nursing texts, any and all reference texts are always helpful. Notebooks, paper, dividers, clipboards, and examples of authentic hospital documents can be used to create simulated charts. However, be mindful of patient confidentiality laws (HIPAA) and do not use any medical documents that contain patient information. Stethoscopes, thermometers, blood pressure cuffs, nametags, penlights, and any other hospital equipment can be used in role-plays.

Model the language and behavior for the students; think aloud while writing and describing.

**Students:** Practice reading and speaking the greeting section. Practice reading and writing the normal assessments. Memorize the word roots. Practice describing and explaining things about medicine and the hospital three different ways: to an adult with *some* medical knowledge, to an adult with *no* medical knowledge, and to a child. Practice answering the question, “what does that mean?”

The body systems in this chapter are presented in the following order:

- NEURO
- CARDIO
- RESP
- GI
- GU
- M/S
- SKIN

➤ **NEUROLOGICAL – BRAIN – NERVOUS SYSTEM**

**Normal assessment:**

Phrases for greeting and assessing the patient:

“Hello. (Introduce yourself). Tell me your name please. Can you tell me where you are? What is the date today? Squeeze my hands please. Smile big, like this. Stick out your tongue. I’m going to shine a light in your eyes. Open your eyes and look straight ahead please. How does your head feel? Do you have a headache? Can you wiggle your toes? Push against my hands with your feet please. Thank you.”

Word roots and terms related to the neurological system:

cephalo- = head.
cerebellum = posterior lobe of brain.
cerebro- = brain.
cranio- = skull.
dura mater = outermost membrane covering the brain and spinal cord.
embolo- = something obstructing a blood vessel; blood clot.
encephalo- = brain.
epidural = a space around the brain and spinal cord (above the dura mater).
foci = focus (pl.).
glia = non-nervous, supportive tissue of brain and spinal cord.
hemi- = half.
lacunar = small area of brain tissue loss from a stroke.
meningo- = membranes covering spinal cord and brain.
neuro- = nervous system or nervous tissue.
occipital = back of the head.
parietal = lobe on upper side of the head.
-paresis = paralysis
-plegia = paralysis.
pons = brain stem.
quad- = four.
subdural = space around brain and spinal cord (below the dura mater).
vaso- = blood vessel.
temporal = side of head; temple.
thrombo- = blood clot.

Commonly encountered disorders/conditions:

cerebral hemorrhage, coma, concussion, CVA (cerebral vascular accident), encephalopathy, epidural hematoma, neuro (brain) trauma, spinal cord injury, subdural hematoma, TIA (transient ischemic attack).
**Translations:**

anisocoria \((n.)\) = the pupils are unequal in size.
antihypertensives \((n., \textit{pl.})\) = medicines to lower blood pressure.
aphasic \((\textit{adj.})\) = the patient can’t talk.
ataxia \((n.)\) = poor coordination; difficulty walking.
carotid ultrasound \((n.)\) = a test to check blockages in arteries that carry blood to the brain.
carotid stenosis \((n.)\) = arteries that carry blood and oxygen to the brain are narrowed or blocked.
confused \((\textit{adj.})\) = mixed up, fuzzy \((\textit{slang})\).
CVA \((n.)\) = stroke \((\textit{cerebrovascular accident})\)
delirium \((n.)\) = confusion, disorientation.
deviated gaze \((n.)\) = the eyes look off in one direction.
drowsy \((\textit{adj.})\) = sleepy; stoned, drunk, rummy, wasted \((\textit{slang})\).
EEG \((n.)\) = a test to check brain activity; records brain waves \((\textit{electroencephalogram})\).
encephalopathy \((n.)\) = temporary confusion from acute illness.
expressive aphasia \((n.)\) = can’t find the right words, can’t talk.
fatigue \((n.)\) = burnt, wiped out, fried, wasted \((\textit{slang})\).
flaccid \((\textit{adj.})\) = limp, unable to move; dead weight, asleep \((\textit{slang})\).
grips \((n., \textit{pl.})\) = hand strength, ability to squeeze hands.
hemorrhagic stroke \((n.)\) = injury caused by bleeding into the brain.
hepatic encephalopathy \((n.)\) = lethargy and confusion due to an elevated ammonia level.
ischemia \((n.)\) = lack of blood flow to a particular area of the brain.
neurosurgeon \((n.)\) = a brain surgeon.
neurologist \((n.)\) = a brain doctor.
obtunded \((\textit{adj.})\) = can’t wake up.
orientation \((n.)\) = awareness of time, place, and situation.
post ictal \((\textit{adj.})\) = the condition after a seizure (usually obtundation).
receptive aphasia \((n.)\) = the patient can’t comprehend what is said.
somnolent \((\textit{adj.})\) = sleepy, lethargic.
stroke \((n.)\) = lack of blood supply to a particular area of the brain; brain tissue death.
seizing \((\textit{v.})\) = having convulsions.
symmetry \((n.)\) = both sides equal, the same.
TIA \((n.)\) = temporary lack of blood flow to particular area of brain \((\textit{transient ischemic attack})\).
tonic-clonic \((\textit{adj.})\) = muscle spasms, jerking.

**Reference pages:**

*Taber’s (20\textsuperscript{th}):* “bones of skull” (p. 2011); “brain” (p. 284); “brain stem” (p. 286);
“cerebrospinal fluid” (p. 811); “cerebrum” (p. 381); “dermatomes” (p. 571);
“emergency situations” (appendix 12-2, pp. 2518-2529); “the interpreter in 3 languages”
(appendix 11, pp. 2481-2495); “medical abbreviations” (appendix 6, pp. 2463-2469);
“nerve” (p. 1445); “normal reference laboratory values” (appendix 3, pp. 2431-2448);
“stroke” (p. 2089); “ventricles of the brain” (p. 2311).
CARDOVASCULAR – HEART – CIRCULATION

Normal assessment:

Heart sounds regular, without murmur, S1S2. Normal sinus rhythm (NSR). Pulses normal all 4 extremities (radial/wrists, dorsalis pedis/feet). Skin warm and dry (W/D), color normal for ethnicity. Capillary refill less than 2 seconds – no edema – MAP ≥ 60 – denies chest pain or pressure, denies shortness of breath (SOB) or dizziness.

Phrases for greeting and assessing the patient:

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“Hello. (Introduce yourself). How are you feeling? Any pain or discomfort in your chest? Can you describe the pain? Does it change when you take a deep breath? Do you have a headache? How about your stomach, any nausea? Do you feel dizzy? I’m going to feel your pulses. I’m going to listen to your heart. Breathe normally please. Thank you. Please let us know right away if you have any chest discomfort so we can treat it, OK? Here’s your call light.”
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Phrases for checking for understanding:

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Do you understand what I said to you? Where is your call button? Can you show me how to use it? When are you supposed to call? If your chest hurts (place hand over your own chest, frown as if in pain), or if you have trouble breathing (keep hand on chest and mimic difficulty breathing). The doctor needs to know if you have chest pain. Or if you feel dizzy (wobble, etc., as if dizzy). So can you tell me when you are supposed to call me? Ask the patient to repeat the instructions back to you. Ask family members to help translate as needed. Incorporate equipment and anatomical diagrams and illustrations from textbooks as visual aids while explaining procedures.
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Word roots and terms related to the cardiovascular system:

- angio- = lymph or blood vessels.
- aorto- = aorta.
- apical = apex.
- arterio- = arteries.
- atrio- = top chambers of the heart.
- brady- = slow.
cardio- = heart.
chrono- = timing.
coronary = arteries supplying blood to the heart.
dys- = bad, difficult, painful.
femoral = groin, femur (thigh bone).
septal = center partition of the heart.
tachy- = fast
thrombo- = clot.
vasc- = blood vessel.
vaso- = blood vessel.
ventriculo- = bottom chambers of the heart.

Commonly encountered disorders/conditions:

ACS (acute coronary syndrome), AS (aortic stenosis), arrhythmias, cardiogenic shock, cardioversion, chest pain, CHF (congestive heart failure), cor pulmonale (right heart failure), hyperlipidemia, mitral valve regurgitation, pacemaker, pericardial effusion, pulmonary edema, R/O MI (rule out myocardial infarction), USA (unstable angina).

Translations:

ACEI (n.) = medicine that lowers blood pressure (angiotensin-converting enzyme inhibitor).
ACS (n.) = chest pain or other symptoms of a heart attack (acute coronary syndrome).
angina (n.) = pain from lack of blood flow and oxygen to the heart.
angioplasty (n.) = using a tiny balloon to open up blocked arteries.
anticoagulants (n., pl.) = blood-thinners.
apprehension (n.) = fear. Afraid, freaked out (adj., slang). “I’m scared.”
arrhythmia (n.) = an irregularity in the heartbeat.
atrial fibrillation (n.) = top chambers of the heart are quivering and not pumping adequately.
Beta blocker (n.) = medicine to help the heart muscle get oxygen, and slow down the rate.
bradycardia (n.) = the heart is beating slower than normal.
cardiac catheterization (n.) = a test to look at the arteries of the heart; angiogram.
cardiac markers (n., pl.) = blood tests: troponin, CK, CK-MB; enzymes, cardiac panel.
cardiologist (n.) = heart doctor.
cardiomyopathy (n.) = a weak heart muscle that doesn’t pump well.
CHF (n.) = heart doesn’t pump adequately, causing congestion (congestive heart failure).
defibrillation (n.) = using electricity to convert an irregular heart rhythm.
digoxin (n.) = medicine to slow and strengthen the heartbeat.
diuretic (n.) = medicine to remove water. Water pill (slang).
dizziness (n.) = vertigo; woozy, gonna pass out (slang). “My head is spinning.”
echocardiogram (n.) = ultrasound images of the heart.
electrolytes (n., pl.) = chemicals in the body like sodium and potassium.
MI (n.) = a heart attack (myocardial infarction).
nitro (n.) = medicine to dilate the blood vessels and help relieve chest pain (nitroglycerin).
stents (n., pl.) = mesh supports to help keep arteries open.
palpitations (n., pl.) = heart’s pounding, heart’s racing (slang).
tachycardia (n.) = the heart is beating faster than normal.
venous Doppler (n.) = an ultrasound to check for blood clots.

Reference pages:

Taber’s (20th): “cardiac valves” (valves, p. 2293); “cardiomyopathies” (p. 342); “circulation of blood through heart and major vessels” (p. 421); “coronary arteries” (p. 172); “Doppler ultrasonography” (p. 2261); “electrocardiogram,” (p. 674); “emergency situations” (appendix 12-2, pp. 2518-2529); “heart” (p. 939); “the interpreter in 3 languages” (appendix 1, pp. 2481-2495); “medical abbreviations” (appendix 6, pp. 2463-2469); “normal reference laboratory values” (appendix 3, pp. 2431-2448).

Oxford Picture Dictionary (1998): 75, “the body” (pp. 74,75); “feelings” (pp. 30-31); “illnesses and medical conditions” (p. 79); “medical and dental exams” (p. 85); “symptoms and injuries” (p. 78).


➤ RESPIRATORY – LUNGS – VENTILATION

Normal assessment:

Respirations even, unlabored – no shortness of breath (SOB) – SpO2 > or = 92% on room air (RA) – able to deep breathe and cough freely – breath sounds clear bilaterally in all lobes – respiratory rate (RR) 16-20/min. – no cyanosis – cough strong, non-congested, non-productive.

Phrases for greeting and assessing the patient:

“Hello. (Introduce yourself). Do you feel short of breath at all? Are you coughing anything up? What color is it? Does it hurt to take a deep breath? I’m going to listen to your lungs. I need to listen to your back. Would you please open your mouth and take deep breaths in and out? You need to keep this oxygen on. Thank you.”
Phrases to check for understanding:

Do you understand what I said to you? Are you having trouble breathing? (Place hand on your own chest and mimic difficulty breathing). To ask about sputum, cough and pretend to spit into a tissue. Ask, is it white or yellow? (point to objects that are those colors if unclear). If a sputum sample is needed, leave the cup at the bedside and have patient demonstrate what they are supposed to do. Do you need a breathing treatment? (take nebulizer and hold it up while asking if the patient’s response is unclear). Can you show me how to find and use your call bell? Call if you have trouble breathing or any other problems. Can you tell me when you are supposed to call? Ask the patient to repeat the instructions back to you. Ask family members to help translate as needed. Incorporate equipment and anatomical diagrams and illustrations from textbooks as visual aids while explaining procedures.

Word roots and terms related to the respiratory system:

alveoli = small air sacs of the lungs.
broncho- = airway.
naso- = nose.
oro- = mouth.
pneumo- = lung; air.
pleura = membrane surrounding the lungs.
pulmo- = lung.
thoraco- = chest wall.
tracheo- = trachea, airway.

Commonly encountered disorders/conditions:

Respiratory failure, COPD (chronic obstructive pulmonary disease), asthma, status asthmaticus, exacerbation of COPD, bronchitis, pneumonia, CHF (congestive heart failure), pulmonary edema, pulmonary embolism, angioedema, anaphylaxis, pneumothorax, hemothorax, fractured ribs, empyema, pleural effusion, lung CA (cancer), thoracotomy, lobectomy.

Translations:

ABG = blood test to check oxygen and carbon dioxide; a gas, a blood gas.
ABG = arterial blood gas; blood is drawn from an artery.
pH = 7.35-7.45. Acid-base balance (< 7.35 acidotic, > 7.45 alkalotic).
pO2 = 75-100. Oxygen.
sat = 96-100. Oxygen saturation.
BE = +/- 2. Base excess.
bronchoscopy (n.) = a test to look into the airways with a scope.
chest tube (n.) = a drain to keep the lung expanded.
chronic obstructive pulmonary disease (COPD) (n.) = emphysema.
dyspneic (adj.) = can’t breathe, short of breath, winded. “I can’t catch my breath.”
empyema (n.) = an infection in the pleural space around the lung.
expectorate (v.) = cough stuff up; hack stuff up (slang).
hand-held nebulizer (HHN) (n.) = breathing treatment, inhalation treatment; updraft nebulizer.
intensivist (n.) = Intensive Care Unit (ICU) doctor.
larynx (n.) = vocal cords; voice box, Adam’s apple (slang).
nasal cannula (n.) = oxygen tubing with prongs in the nose.
nasal congestion (n.) = nose is stuffed up, head is stopped up (slang).
pharynx (n.) = throat.
pneumonia (n.) = lung infection.
pulmonologist (n.) = lung doctor.
pursed-lip breathing (n.) = to exhale as if blowing out a candle
rhinorrhea (n.) = runny nose, sniffly (slang).
sputum (n.) = mucus, phlegm.
tachypneic (adj.) = breathing faster than normal.
trachea (n.) = windpipe.
tracheostomy (n.) = an opening in the trachea, in the front of the neck.
Yankauer (n.) = oral suction apparatus.

Reference pages:

Taber’s (20th): “bag-valve-mask resuscitator” (p. 217); “embolism” (p. 683); emergency situations” (appendix 12-2, pp. 2518-2529); “endotracheal tube” (p. 709); “features of bronchodilator drugs,” (p. 298); “the interpreter in 3 languages” (appendix 11, pp. 2481-2495); “larynx” (p. 1207); “lobar pneumonia” (p. 1697); “lungs” (p. 1270); “medical abbreviations” (appendix 6, pp. 2463-2469); “normal reference laboratory values” (appendix 3, pp. 2431-2448); “pneumothorax” (p. 1699); “pulmonary embolism” (p. 684); “rate of respirations” (breaths/min.) (p. 1884); respiratory system” (p. 1888); “trachea and bronchi” (p. 300), “tracheostomy tube” (p. 2213).

Oxford Picture Dictionary (1998): “the body” (p. 75); “colors” (p. 12); “feelings” (pp. 30, 31); “health care” (p. 81); “illnesses and medical conditions” (p. 79); “medical and dental exams” (p. 85); “medical emergencies” (p. 82); “symptoms and injuries” (p. 78).

Advanced Cardiac Life Support textbook, Basic Life Support (BLS)/CPR textbook, Pediatric Advanced Life Support textbook; anatomy and physiology textbooks, respiratory therapy textbooks, Lippincott Manual of Nursing Practice.
Normal assessment:

Abdomen soft, non-tender, non-distended – active bowel sounds auscultated in all 4 quadrants (x 4). Denies nausea, vomiting (N/V), or pain. Passing flatus. Denies constipation or diarrhea. Stool guaiac negative. Last bowel movement (BM) ____ (within last 3 days).

Phrases for greeting and assessing the patient:

“Hello. (Introduce yourself). How are you feeling? Any pain or discomfort in your abdomen? Are you nauseated? Have you thrown up at all? I’m going to listen to your abdomen. I’m going to press on your belly—tell me if it hurts. Are you passing gas? Have you had a bowel movement lately? Is it normal, or diarrhea? Please let us know if you have a bowel movement, and don’t flush the toilet, so we can check it—the doctor wants to know if there’s any hidden blood in it. Thank you.”

Phrases to check for understanding:

Do you understand what I said to you? Does your abdomen hurt? (place your hand on your own abdomen while asking questions about pain or discomfort). Any nausea or vomiting? (pick up emesis basin to ask about nausea or vomiting). Point to toilet handle and ask not to flush by shaking head ‘no.’ Where is your call bell? Can you show me how to use it? When are you supposed to call me? Pick up containers to demonstrate when a sample is needed. Have patient demonstrate that he/she knows where the container is and how to use it. Ask the patient to repeat the instructions back to you. Ask family members to help translate when needed. Incorporate equipment and anatomical diagrams and illustrations from textbooks as visual aids while explaining procedures.

Word roots and terms related to the gastrointestinal system:

bili- = bile  
cecum = first part of the large intestine.  
chole- = gallbladder.  
colo- = colon (large intestine).  
duodeno- = duodenum (first part of small intestine).  
entero- = intestines.  
esophago- = esophagus (tube from mouth to stomach).  
fecal = waste, stool.  
gastro- = stomach.  
hepato- = liver.  
oro- = mouth.  
-ostomy = opening.
pancreo- = pancreas.
ileal- = ileum (lower part of small intestine).

Commonly encountered disorders/conditions:

adhesions, appendicitis, ascites, bowel obstruction, bowel resection, cholecystectomy, cholecystitis, cirrhosis, colectomy, colon CA (cancer), colostomy, Crohn’s disease, diverticulitis, DT’s (delirium tremens), esophageal varices, exploratory laparotomy, gastritis, gastrostomy, GERD (gastroesophageal reflux disease), GI (gastrointestinal) bleed, hepatitis, ileostomy, incarcerated bowel, irritable bowel syndrome, ischemic bowel, jaundice, Mallory-Weiss tear melena, N/V (nausea and vomiting), necrotic bowel, perforated viscus, pancreatitis, paralytic ileus, pancreatitis, portal hypertension, obstruction, ulcer.

Translations:

abdomen (n.) = belly, tummy, gut, stomach.
bowel prep (n.) = strong laxative to clean out the intestines so the doctor can see inside.
bowel movement (v.) = go potty, number two, poop (slang). “I have to go to the bathroom.”
cholecystitis (n.) = the gallbladder is inflamed.
colonoscopy (n.) = a test to look into the colon with a scope.
constipated (adj.) = clogged up; bound up; have to go, but can’t.
diarrhea (n.) = liquid stool; have the runs (slang).
distended (adj.) = bloated.
EGD (n.) = a scope of the esophagus and stomach (esophagogastroduodenoscopy).
epigastric pain (n.) = heartburn; acid stomach; stomachache.
flatus (n.) = intestinal gas; to pass gas, fart (v., slang).
gastroenterologist (n.) = stomach, liver, and intestines doctor.
guaiac (v.) = to test for hidden blood in the stool.
hyperactive bowel sounds (n., pl.) = rumbling, churning, gurgling.
hepatitis (n.) = the liver is inflamed.
ilus (n.) = the intestines are not active like they should be.
lap chole (n.) = to remove the gallbladder by making little incisions and using a laparoscope.
LIS (n.) = suction applied to a nasogastric tube, as well as other drains (low intermittent suction).
melena (n.) = black stool caused by bleeding in the digestive tract.
nauseated (adj.) = feel sick to the stomach; queasy, puky (slang). “I’m gonna throw up.”
NGT (n.) = this tube goes through the nose into the stomach (nasogastric tube).
retching (v.) = dry heaves, vomiting.
upper GI (n.) = to swallow barium and take a picture of the esophagus and stomach.
vomit (v.) = throw up, puke, barf (slang).
Reference pages:

*Taber’s* (20th): “abdominal regions” (p. 4); “biliary tract” (p. 2215); “colon and rectum” (p. 450); “emergency situations” (appendix 12-2, pp. 2518-2529); “hemorrhoids” (p. 975); “hiatal hernia” (p. 984); “the interpreter in 3 languages” (appendix 11, pp. 2481-2495); “large intestine” (p. 1129); “medical abbreviations” (appendix 6, pp. 2463-2469); “normal reference laboratory values” (appendix 3, pp. 2431-2448); “pancreas” (p. 1577); “stomach,” (p. 2080).

*Oxford Picture Dictionary* (1998): “the body” (pp. 74, 75); “clinics” (p. 84); “colors” (p. 12); “feelings” (pp. 30, 31); “health care” (pp. 80, 81); “illnesses and medical conditions” (p. 79); “medical and dental exams” (p. 85); “symptoms and injuries” (p. 78).


➤ GENITOURINARY – RENAL – KIDNEYS AND BLADDER

Normal assessment:

Voiding spontaneously without difficulty. Urine clear yellow, quantity sufficient (QS). No pain or discomfort with urination – no incontinence – urine non-malodorous. Foley catheter patent, draining clear yellow urine.

Phrases for greeting and assessing the patient:

“Hello. (Introduce yourself). How are you feeling? Are you urinating OK? No pain or problems? Please use the urinal so we can see it and measure it. Please let us know when you go so we can see it, keep track, and measure it. We have to measure everything for the doctor. Next time you go, we need a sterile urine specimen, OK? You have to go directly into this clean container, not in the urinal or pan that’s already been used. Call us when you’re ready—here’s your call bell. Thank you.”

Phrases to check for understanding:

Do you understand what I said to you? Point to urinal or other receptacle to indicate that fluids need to be measured. Have the patient demonstrate how to locate and use the receptacle for a specimen. Can you show me how to find and use your call bell? Now, should you save the urine, yes or no? Ask the patient to repeat the instructions back to you. Incorporate equipment and anatomical diagrams and illustrations from textbooks as visual aids while explaining procedures. Ask family members to help translate as needed.
Word roots and terms related to the genitourinary system:
calculus = stone.
cysto- = bladder.
litho- = stone.
uro- = urine
uretero- = ureter.
urethro- = urethra.
renal = kidney.
nephro- = kidney.

Commonly encountered disorders/conditions:
acute tubular necrosis (ATN), acute renal failure (ARF), benign prostatic hypertrophy (BPH), chronic renal failure (CRF), dialysis, kidney stone, kidney transplant, nephritis, prostate CA (cancer), renal CA, renal insufficiency, rhabdomyolysis, UTI (urinary tract infection), urosepsis.

Translations:
clean catch urine (n.) = a mid-stream urine sample.
incontinence (n.) = leak; dribble, have an accident (slang).
implant a Foley catheter (v.) = to put a soft tube in the bladder that drains the urine.
KUB (n.) = an x-ray of the abdomen (kidneys, ureters, bladder).
nephrologist (n.) = kidney doctor, dialysis doctor.
patent (adj.) = wide open (not obstructed).
urinal (n.) = a bottle to urinate in.
urinate (v.) = pee; wee-wee, piss, go number one, tinkle (slang).
urologist (n.) = bladder and kidney doctor.
UTI (n.) = bladder infection (urinary tract infection).
void (v.) = to urinate; pee.

Reference pages:
Taber's (20th): “female genitalia” (p. 868); “formation of urine” (p. 1175); “the interpreter in 3 languages” (appendix 11, pp. 2481-2495); “kidney” (p. 1173); “male genitalia” (p. 869); “medical abbreviations” (appendix 6, pp. 2463-2469); “nephron” (p. 1174); “normal reference laboratory values” (appendix 3, pp. 2431-2448); “penis” (p. 1620); “urinary system” (p. 2274).

Oxford Picture Dictionary (1998): “the body” (pp. 74,75); “clinics” (p. 84); “colors” (p. 12); “feelings” (pp. 30, 31); “health care” (pp. 80, 81); “hospital” (p. 87); “illnesses and medical conditions” (p. 79); “medical and dental exams” (p. 85); “patient’s room” (p. 86); “symptoms and injuries” (p. 78).
NORMAL ASSESSMENT:

Moves all extremities (MAE) equally – coordinated – normal strength, sensation – gait strong, steady – able to stand and transfer without assistance – no dizziness – no assistive devices required – no numbness or tingling – skin warm, dry (W/D) – no edema.

Phrases for greeting and assessing the patient:

“Hello. (Introduce yourself). How are you doing? Any pain or problems? Any numbness or tingling anywhere? Let’s check your circulation. I’m going to feel your pulses. Here’s a pillow to put your leg on. It helps to keep the limb elevated, higher than your heart, to help with swelling. Physical therapy is going to work with you today. You need to be extra careful and call for help if you want to get up, OK? Please don’t try to get up alone. Here’s your call bell. Thank you.”

Phrases to check for understanding:

Do you understand what I said to you? Simulate getting up alone and shake your head ‘no’ when instructing not to get up alone. Can you show me how to find and use your call bell? And when should you call? Are you supposed to get up alone? Yes or no? Ask the patient to repeat the instructions back to you. Incorporate equipment and anatomical diagrams and illustrations as visual aids while explaining procedures. Ask family members to help translate as needed.

WORD ROOTS AND TERMS RELATED TO THE MUSCULOSKELETAL SYSTEM:

ortho- = straight.
myo- = muscle.
arthro- = joint.
fascio- = fibrous membrane.
chondro- = cartilage.
costo- = rib.
ilio- = ilium; flank.
lumbo- = lower back.
osteo- = bone.
sacro- = sacrum (lowest part of back).
sterno- = sternum.
Commonly encountered disorders/conditions:

amputation, arthritis, disectomy, dislocation, fasciotomy, fracture, hip fracture, hip replacement, knee arthroscopy, knee replacement, ORIF (open reduction and internal fixation), pinning, rotator cuff repair, tendonitis, torn ligament.

Translations:

dressing (n.) = bandage, gauze.
edematous (adj.) = swollen, puffy.
fatigued (adj.) = tired, exhausted; wiped out, drained, weak.
numb (adj.) = asleep, dead weight (“my leg’s asleep”).

orthopedic surgeon (n.) = bone/muscle doctor.
to be in pain (v.) = it hurts, it is killing me; “ow!”

PCA or CADD (n.) = the patient’s pain button; pain medicine (patient-controlled analgesia, continuous ambulatory drug delivery).

SCD’s (n., pl.) = apparatus to help the circulation in the legs and prevent blood clots (sequential compression devices).
sutures (n., pl.) = stitches.

Trendelenburg (n.) = positioning a patient with the foot of the bed up, head down (inverted).

unsteady (adj.) = wobbly, woozy, weak, “feel like I’m gonna fall.”

Reference pages:

Taber’s (20\textsuperscript{th}): “bones of skull” (p. 2011); “bony structures of the thorax” (p. 276); “fracture” (p. 830); “the interpreter in 3 languages” (appendix 11, pp. 2481-2495); “muscle” (p. 1402); “muscles of the leg” (p. 1218); “skeleton” (p. 2007).

Oxford Picture Dictionary (1998): “colors” (p. 12); “feelings” (pp. 30, 31); “first aid” (p. 83); “health care” (pp. 80, 81); “hospital” (p. 86); “medical emergencies” (p. 82); “outdoor recreation” (p. 154); “sports equipment” (p. 161); “sports verbs” (pp. 156, 157); “team sports” (p. 158); “winter sports and water sports” (pp. 159, 160).

Nursing textbook, nursing drug handbook, anatomy text.

\begin{itemize}
\item INTEGUMENTARY – SKIN – WOUNDS
\end{itemize}

Normal assessment:

Skin warm & dry (W/D) – color normal for ethnicity – no rashes or lesions – mucous membranes pink and moist.
Phrases for greeting and assessing the patient:

“Hello. (Introduce yourself). How are you feeling? I need to look at your skin. Would you turn over on your side please? I’ll help you. We need to keep pressure off of your back. It’s bad for your circulation to stay in one position too long. Let’s look at your rash. I have some medicine to put on that. We need to keep things clean and dry. I’m going to look at your incision. I need to change this dressing. You need to eat and drink to help this wound heal. Thank you.”

Phrases to check for understanding:

Do you understand what I said to you? Why do you need to stay off of your back? Why do you need to eat and drink? Can you show me where your call bell is? Can you show me how to call? Why is it important to eat and drink? Incorporate equipment and anatomical diagrams and illustrations as visual aids while explaining procedures. Ask the patient to repeat the instructions back to you. Ask family members to help translate as needed.

**Word roots and terms related to the integumentary system:**

- *derm-* = skin.
- *dermato-* = skin.
- *kerato-* = horny substance or cornea.
- *integument* = covering; skin.
- *decubitus* = lying down; pressure sore.
- *subcutaneous* = beneath the skin.

**Commonly encountered disorders/conditions:**

- abrasions, abscess, burns, cellulitis, decubitus ulcer, incision & drainage (I & D), ischemia, necrosis, venous stasis ulcer, surgical wound dehiscence.

**Translations:**

- abrasion (*n.*) = scrape.
- acne (*n.*) = pimples; broken out.
- blanching (*v.*) = white spots.
- breakdown (*n.*) = skin that is deteriorating due to lack of blood supply, moisture, or infection.
- denuded (*adj.*) = raw.
- dermatologist (*n.*) = skin doctor.
- diaphoretic (*adj.*) = sweaty.
- ecchymoses (*n., pl.*) = bruises.
- erythema (*n.*) = redness, rash.
irrigate (v.) = flush, rinse.
lesions (n., pl.) = sores.
macule (n.) = a flat spot on the skin, different in color from surrounding area.
necrotic (adj.) = dead tissue, usually black in color.
papules (n., pl.) = bumps on the skin.
pruritus (n.) = itching.
psoriasis (n.) = a chronic skin condition which causes red, scaly patches.
sallow (adj.) = a sickly yellow color.
sanguineous (adj.) = bloody
saturated (adj.) = soaked.
serous (adj.) = serum; yellow or straw-colored fluid.
vesicle (n.) = blister.

Reference pages:

*Taber’s* (20th): “the interpreter in 3 languages” (appendix 11, pp. 2481-2495); “medical abbreviations” (appendix 6, pp. 2463-2469); “necrosis” (p. 1435); “pressure sore” (p. 1771); “ringworm” (p. 1919); “skin section” (p. 2009); “urticaria” (p. 2279); “venous stasis ulcer” (p. 2260).

*Oxford Picture Dictionary* (1998): “the body” (pp. 74, 75); “colors” (p. 12); “first aid” (p. 83); “health care” (pp. 80, 81); “illnesses and medical conditions” (p. 79); “personal hygiene” (pp. 76, 77); “symptoms and injuries” (p. 78).

Chapter 2: Patient Care

This section contains examples of language used during patient care, and daily routines such as bathing and eating. All nursing personnel participate in all aspects of patient care, and that care is accompanied by conversation. In some units a total care approach is used, wherein a licensed nurse performs all duties, such as assessment, bathing, feeding, and administering medications alone (as in my unit). On other floors, there may be a team-led arrangement, with an RN overseeing other nurses. One nurse may distribute medications, or all nurses may administer medications to their assigned group of patients. Certified nursing assistants may take vital signs, serve meals, and bathe patients. In an acute care setting, RN’s do answer call lights, change bedding, clean up spills, help patients go to the bathroom, and take vital signs as needed; this work is not limited to nursing assistants only.

Some of this language includes colloquial and slang terms, pain assessment scales and descriptions, and ways patients may describe their symptoms. Some British and American terms are included for comparison.

Teachers: Language forms and functions in this category include, but are not limited to, prepositions, articles, present progressive tense, past participles, asking, directing, explaining, expressing likes and dislikes, and describing feelings.
Possible classroom activities can involve creating a patient information card, interpreting diet and activity orders, helping patients fill out a hospital menu, and giving and receiving report about the patient’s day. Students can practice organizing and prioritizing care for several patients. Each one can develop his or her personalized organizational worksheet. As a group the class can discuss similarities and differences in hospital daily routines, practices, and equipment in various countries and cultures. Issues of modesty and how pain is expressed and treated are important class topics. Suggested materials include disposable dishes and utensils, bottled water, water pitchers, straws, and tissues. Actual hospital equipment can help with role-plays, such as thermometers, stethoscopes, pen lights, and watches with second hands. Smocks, lab coats, and nametags can help students “get into character.” Any and all available medical and nursing reference texts, posters, and illustrations should be handy. Charts can be assembled and simulated with binders, paper, dividers, and clipboards. Any authentic documents are best, but be sure to ask permission to use anything with an organization’s name or logo, and do not use any private patient information. Cultural discussions and debriefing may allow students to talk about stressful situations and how they cope.

**Students:** Keep a journal of your experiences in class and in the hospital.

Topics in this chapter are listed in the following order:

- **ADL’s**
- **BRITISH VS. AMERICAN TERMS**
- **IV’s**
- **NUTRITION**
- **PAIN**
- **WEIGHTS AND MEASURES**

**Translations:**

ambulate = walk; go for a walk.
bathe = take a bath, wash up, clean up.
bath items = toiletries.
bedpan = pot, pan.
bedside commode (BSC) = pot; potty; potty chair; commode; toilet.
change bedding = change your sheets, freshen your bedding, get you a new pillowcase, etc.
dangle = sit on the side of the bed.
emesis basin = spit pan.
facial tissues = Kleenex.
oral care = brush your teeth, clean your mouth, swish and spit, rinse your mouth.
partial bath = freshen up, spit bath, sponge bath.
patient belongings = my stuff; my things; my bag.
peri care = wipe, wash down below, clean your privates.
wash basin = bucket, pan.

Asking for help:

“Could you please help me reposition my patient?”
“I’m sorry, I don’t understand.”
“I’m sorry, I didn’t hear you.”
“Could you please repeat that?”

Reference pages:

clothes” (pp. 70, 71), “feelings” (pp. 30, 31), “personal hygiene” (pp. 76, 77), “preposi-
tions” (p. 13), “prepositions of motion” (p. 105).

➤ BRITISH (BrE) AND AMERICAN (AmE) ENGLISH TERMS

A&E: accident and emergency (BrE) . . . . . emergency room, ER, ED (AmE).
antenatal . . . . prenatal, perinatal.
apyrexic . . . . afebrile.
BNO: bowels not open . . . . . not stooling; constipated.
bum . . . . . . . . . . bottom, butt.
bunged-up . . . . . constipated.
caecum . . . . . cecum.
canteen . . . . . cafeteria.
catarrh . . . . . runny nose.
chilblains . . . . . fingers frostbitten.
chips . . . . . . . . . . French fries.
chiropodist . . . . . podiatrist.
corridor . . . . . hall, hallway.
cyanosed . . . . . cyanotic.
crisps . . . . . . . . . . chips.
dressing gown . . . . . nightie.
dungarees/trousers . . . . . pants.
dyspnoea . . . . . dyspnea.
faeces . . . . . . . . . . feces.
farina . . . . . hot cereal, cream of wheat.
flat (n.) . . . . . apartment.
fortnight . . . . . 2 weeks.
FUO: fever of unknown origin.
gippy . . . . diarrhea, intestinal distress.
gripes . . . . intestinal cramping.
gullet . . . . throat.
haematology . . . . hematology.
handover (n.) . . . . report, shift change.
hawking . . . . hacking, difficulty clearing throat, producing phlegm.
hordeolum . . . . stye.
HPU: has passed urine . . . . has voided, voiding.
in hospital . . . . in the hospital, hospitalized.
kidney dish . . . . emesis basin.
knickers . . . . underwear.
loin . . . . groin.
the loo . . . . bathroom, toilet.
meter . . . . 3 ft., a yard.
MSU: mid-stream urine specimen . . . . clean catch UA.
NAD: nothing abnormal detected . . . . WNL: within normal limits.
NBM: nil by mouth . . . . NPO: nothing by mouth.
nightdress . . . . nightie, robe.
NPU: not passing urine . . . . no urine output, anuric.
obs . . . . vital signs, assessment.
oesophagus . . . . esophagus.
operating theatre . . . . OR, operating room, surgery.
out of puff . . . . short of breath, winded, dyspneic.
piles . . . . hemorrhoids.
porridge . . . . hot cereal, oatmeal.
porter . . . . orderly, transporter.
practise . . . . practice.
PUO: pyrexia of unknown origin . . . .
pajamas . . . . pajamas.
pyrexia . . . . fever, febrile.
scone . . . . biscuit, roll.
serviette . . . . napkin.
sister . . . . nurse.
sonography . . . . ultrasound, Doppler.
stone/6.3kg . . . . 14lb.
strangury . . . . dysuria.
stretcher . . . . gurney.
torch . . . . flashlight.
to ring . . . . call, telephone.
trolley . . . . cart.
verruca . . . . warts.
ward . . . . unit, floor.
ward sister . . . . charge nurse, nurse’s aide, nurse?
waterworks . . . . bladder, urination.
IV’s

Normal IV site:

No redness, swelling or tenderness – skin not cool to touch – site flushes easily – labeled with date and time IV started – dressing clean, dry and intact (CDI) – no drainage or leakage at site.

Translations:

art line (n.) = arterial line used for monitoring blood pressure and drawing blood.
blood return (n.) = flashback.
bad IV site (n.) = IV’s blown, shot, no good, infiltrated, needs a new IV.
bolus (n.) = dose of fluid or medication given quickly.
central line (n.) = IV access in a large vein (usually jugular or subclavian).
CVP (central venous pressure) line (n.) = a large IV in chest or neck.
drips (n., pl.) = continuously running IV medications.
field start (n.) = IV started by paramedics outside of hospital.
infiltrated (adj.) = fluid has leaked out of the vein into the tissue.
IV cannula (n.) = tiny plastic tube that sits inside the vein.
IV (n.) = intravenous line.
IVF (n., pl.) = IV fluids.
IVP (n.) = IV push.
occluded (adj.) = blocked off.
secondary tubing/medication (n.) = piggy back (IVPB); partial fill (IVPF).
patent (adj.) = open; able to flush.
PICC (n.) = peripherally inserted central catheter (starts in arm, goes up into subclavian vein).
Porta-cath (n.) = access device for surgically implanted central line.
primary IV (n.) = main IV; IV number one.
saline lock (n.) = IV site capped off, periodically flushed with saline; heplock.
TPN (n.) = total parenteral nutrition (feeding via a central line).
wide open (adj.) = IV drip rate as fast as possible; 999 ml/hr.

NUTRITION – MEALS – EATING – FOOD

aspiration precautions = “You need to sit up straight and put your chin down when you swallow so you don’t choke.”
fluid restriction = “The doctor wants to limit your water and fluid intake.”
FSBS before meals = “I need to check your blood sugar before you eat.”
I and O = “We have to measure everything you eat and drink.”
NPO = nothing by mouth; “Nothing to eat or drink”; “You can only wet your mouth.”
“You can only have ice chips.”
snack = a little something to eat; a nibble; a few bites.
**Normal assessment:**

Denies pain or discomfort. Resting comfortably. No signs/symptoms of distress.

**Pain scales:**

0-10: “what hurts? Can you describe the pain? Can you give it a number from 1-10?”

**FLACC:** note physical signs of **facial expression**, leg movement, arms, crying, consolation.

**Physical symptoms of distress:**

Tachypnea (increased RR), tachycardia (increased HR), elevated blood pressure, grimacing, restlessness, writhing, crying, moaning, confusion.

Wong-Baker faces: sad, neutral, happy to depict feeling (point to picture).

**Translations:**

anxious (**adj.**) = nervous, stressed out, overwhelmed, jittery, can’t relax, freaking out, tense, keyed up.

anxiolytic (**n.**) = sedative, tranquilizer, nerve pill.

benzodiazepines (**n., pl.**) = sedatives such as Valium, Ativan, and Xanax.

c/o = complains of.

fear (**n.**) = scared, terrified, nightmares.

hallucinations (**n., pl.**) = seeing things, hearing voices, hearing things, imagining things.

hypnotic (**n.**) = sleeping pill.

irritable (**adj.**) = crabby, depressed, pissed off, tense, angry, want to be alone.

narcotic (**n.**) = pain medicine such as morphine, Demerol, and Vicodin.

NSAIDS (**n., pl.**) = pain pills such as Advil and Aleve.

**Reference pages:**

Chapter 3: Weights and Measures

It is helpful to practice measuring, calculating, and documenting in the classroom before working in a stressful clinical environment. This section includes a list of some of the weights and measures nurses encounter on a daily basis. There are some dosage calculation formulas, and height, weight, and temperature scales. The language here is about numbers, math, and pharmacology.

**Teachers:** Forms and functions include wh-questions, mathematical and scientific terms, drug names, measuring tools, and volume. Students will state names and measurements, and ask for clarification and/or confirmation.

Classroom activities can include interpreting and transcribing medication orders.

An overview of pharmacology, with drug names, classes, actions, and routes will require extensive memorization. Students can practice calculating and measuring drug dosages, administering the medications, and documenting on the medication administration record (MAR). It is safe to encourage “three checks” — cross checking the name, dose, and frequency of the drug three times (and also its expiration date). Students may also hear what’s known as “the five rights of medication administration”—right patient, right medication, right dose, right route, and right time. This requires comparing the name, date of birth, and medical record number on the MAR to the patient’s arm band; if there is no arm band, students must ask the patient to state his or her name and date of birth.

Suggested materials include med cups, syringes, measuring spoons, graduated cylinders, and any other utensils. Fruit punch, juice, and small candies of various shapes and sizes can function as the meds. Any and all available medical and nursing reference texts should be handy, as well as drug handbooks. You will need pencils, paper and calculators. Binders, paper, dividers, and clipboards can be used to assemble and simulate patient charts. Authentic MAR’s would be best, but samples can be created using grids and columns. Be careful to avoid potential HIPAA violations.

**Students:** Practice measuring at home, using kitchen utensils. Practice these checks *every* time you give a medication: check the name of the med, the generic name, the dose, the route, the frequency, the patient’s name and date of birth, the patient’s allergies, and the time for accuracy. Carry the paper copy of the MAR into the room and compare it to the patient’s nameband. Wait and open the pills at the bedside and tell the patient what they are.
WEIGHTS AND MEASURES

Dosage calculations:

dose: dose/unit of measure x volume = quantity (D/H x Q = X).
1 mg = 1000 mcg (mg x 1000)
ml/hr. = volume (ml)/time (hours)
gtts/min. = volume (ml) to be infused x gtt factor/total time in minutes: (ml x gtts)/min.

Titrated drips:

1. determine concentration per one ml: mg/ml or mcg/ml = conc.
2. find your computation constant (k): conc./60 = k
3. get pt. weight in kg
   mg/min.: dose/k = rate on pump
   rate on pump x k = dose
   mcg/min.: dose/k = rate on pump
   rate on pump x k = dose
   mg /kg/min.: rate on pump = (dose/k) x kg
   (rate on pump x k)/kg = dose
   mcg/kg/min.: rate on pump = (dose/k) x kg
   (rate on pump x k)/kg = dose

Length:

record all length in centimeters (1 cm = 3/8 inch; 1 inch = 2.54 cm)
height: 5 feet = 60 inches; 5 feet = 152 cm
6 feet = 72 inches; 6 feet = 183 cm
1 inch = 2.54 cm

Measurements:

mean arterial blood pressure: (MAP) = DBP + (PP/3)
pulse pressure: (PP) = SBP – DBP
anion gap = Na – (Cl + HCO3)

Temp:

normal: 98.6 F. = 37 C.
Fahrenheit to Celsius: (F – 32)/1.8 = C.
Celsius to Fahrenheit: (C x 1.8) + 32 = F.
97 F. = 36.1 C.
98 F. = 36.7 C.
99 F. = 37.2 C.
100 F. = 37.7 C.
100.5 F. = 38 C.
101 F. = 38.3 C.
101.5 F. = 38.6 C.
102 F. = 38.8 C.
103 F. = 39.4 C.
104 F. = 40 C.
105 F. = 40.6 C.

**Volume:**

- record all weights in kilograms (1 kg = 2.2 lb)
- weigh all diapers (deduct dry diaper weight)
- graduate = 1000 ml (1 liter)
- water pitcher = 1000 ml (1 liter) (approx.)
- 1 kg = 1000 ml (1 liter)
- emesis basin = 500 ml
- 8 oz. carton of milk = 240 ml
- cup of coffee, hot chocolate, tea, broth = 180-200 ml (approx.)
- 4 oz. juice, jello, ice cream, popsicle = 120 ml
- 1 unit of blood (PRBC’s) = 300-400 ml
- 1 g = 1 ml
- 1 teaspoon = 5 ml
- 1 Tablespoon = 15 ml
- 1 ounce (oz.) = 30 ml (1 med cup)
- 1 cup = 240 ml
- 1 pint = 500 ml
- 1 quart = 1000 ml

**Reference pages:**

*Taber’s* (20th) see Appendix 8: “units of measurement” (p. 2471).

*Oxford Picture Dictionary* (1998): mathematics” (p. 118); “numbers and measurements” (pp. 14, 15); “restaurant” (p. 63); “science” (p. 119); “weather” (p. 10); “weights and measures” (p. 57).

**Chapter 4: Glossary of Terms**

This is a partial list of the many abbreviations and acronyms routinely encountered in the hospital. There are endless possibilities for word games, puzzles, cloze quizzes, matching definitions and categorizing. Materials can include terms on this list, flashcards, posters, dictionaries, encyclopedias, etc. Samples of physicians’ progress notes, orders, and patient histories can be deciphered. Be cautious of potential HIPAA violations.
GLOSSARY


* Alphabetisms are pronounced as a single word.

ā = ante (before) written with a horizontal line over the top.
AB = antiobiotic
ABG = arterial blood gas
āč = before meals (with a horizontal line over both letters)
AC = antecubital (inner elbow)
ACLS = advanced cardiac life support
ACS = acute coronary syndrome (USA, CP)
ADL’s = activities of daily living
AICD = automatic implanted cardiac defibrillator
AKA = above the knee amputation
appy* = appendectomy
ARF = acute renal failure
ARM = antibiotic-resistant microorganisms (MRSA, VRE)
ASAP* = as soon as possible
ASHD = atherosclerotic heart disease
ATN = acute tubular necrosis (kidneys)
Ax = axillary
BAER* (“bare”) = brainstem auditory evoked response (neuro test)
bag = manually ventilate (breathe)
BE = barium enema; base excess (pH, ABG)
bilat. = bilateral (both sides)
BKA = below the knee amputation
BM = bowel movement (stool)
BP = blood pressure
brady- = slow
BS = blood sugar; bowel sounds
BSC = bedside commode (toilet, potty)
č = with (written with a horizontal line over the top)
Ca++ = calcium
CA = cancer
CABG = coronary artery bypass graft (open-heart surgery)
CAD = coronary artery disease
CADD* = continuous ambulatory drug delivery (pump)
CAPA* (“kappa”) free = no coffee, aspirin, pepper, alcohol (diet)
C & S = culture and sensitivity (test for microorganisms)
cath = cardiac catheterization (angiogram, heart cath)
CBC = complete blood count (hematology)
c.diff = clostridium difficile toxin
CEA = carotid endarterectomy (surgery)
CHF = congestive heart failure
chole = cholecystectomy (surgery)
CNS = central nervous system
c/o = complains of
COPD = chronic obstructive pulmonary disease (emphysema)
cor pulmonale = right heart failure
CO2 = carbon dioxide
CP = chest pain
CPM = continuous passive movement (knee machine)
CRF = chronic renal failure
crit = hematocrit
CT = computed tomography (CAT scan)
cult = culture (to grow out microorganisms in lab)
CVA = cerebrovascular accident (stroke)
CVP = central venous pressure
CXR = chest x-ray
Davol = surgical drain
DBP = diastolic blood pressure (bottom number)
D5W = dextrose 5% in water (IV)
D50 = dextrose 50% in water (IVP, for hypoglycemia)
DKA = diabetic ketoacidosis (blood sugar out of control)
decub = decubitis ulcer (bedsore, pressure sore/ulcer)
DM = diabetes mellitus
DOB = date of birth
DPAHC* (“d-pack”) = durable power of attorney for health care
D10 = dextrose 10% in water (IV)
DT's = delirium tremens (alcohol withdrawal)
DVT = deep vein thrombosis (blood clot)
EBL = estimated blood loss
ECG = electrocardiogram (EKG)
echo = echocardiogram (US of heart)
ED = emergency department (ED)
EEG = electroencephalogram (check brain waves)
EGD = esophagogastroduodenoscopy
EKG = electrocardiogram (ECG)
EPO = erythropoietin (Epogen)
ER = emergency room (ED)
ERCP = endoscopic retrograde cholangiopancreatography
ESBL = extended-spectrum Beta-lactamase (ARM)
ESR = erythrocyte sedimentation rate (sed rate)(hematology)
ET tube = endotracheal tube (artificial airway)
ETT = exercise treadmill test (heart stress test)
ETOH = alcohol (ethanol)
Fe = iron
FeSO₄ = iron (ferrous sulfate)
FFP = fresh frozen plasma (blood product; serum)
FiO₂ = oxygen patient is receiving
FLACC = faces, legs, arms, crying, consolability (pain scale)
FOB = foot of bed
FSBS = finger stick blood sugar (Accuchek)
F/U = follow-up
gas = arterial blood gas (ABG)
GB = gall bladder
GERD* = gastroesophageal reflux disease (heartburn)
GI = gastrointestinal
gluc = glucose (sugar)
gtt = drip (IV) or drop (meds)
G-tube = gastrostomy tube (PEG)
GU = genitourinary
guaiac = occult blood test (Hemoccult®)
H & H = hemoglobin and hematocrit (hemogram)
HCO₃⁻ = bicarb
Hct = hematocrit
heart cath = cardiac catheterization (angiogram)
hemogram = H & H
hep C = hepatitis C
Hgb = hemoglobin
HHN = hand-held nebulizer
HIDA* scan = hepatobiliary iminodiacetic acid scan (gall bladder scan)
H₂O = water
HOB = head of bed
HOH = hard of hearing
HR = heart rate (pulse)
HS = bedtime
HTN = hypertension (high BP)
ICP = intracranial pressure
IDDM = insulin-dependent diabetes mellitus
IM = intramuscular (injection)
INR = International normalized ratio (coags)
intubated = on ventilator, life support (ET tube)
I & O = intake and output (fluid balance)
IPPB = intermittent positive pressure breathing
IV = intravenous
IVF = intravenous fluids
IVP = intravenous push; intravenous pyelogram (renal study)
IVPB = intravenous piggyback
J.C.A.H.O.* (“jake-o”) = Joint Commission on Accreditation of Hospital Organizations
JP = Jackson-Pratt (bulb drain)
K+ = potassium
KUB = kidneys, ureters, bladder (x-ray of abdomen)
LIS = low intermittent suction
LLE = left lower extremity (leg)
LLL = left lower lobe (lung)
LLQ = left lower quadrant (abdomen)
LUE = left upper extremity (arm)
LUL = left upper lobe (lung)
LUQ = left upper quadrant (abdomen)
lytes = electrolytes
MgSO4 = magnesium sulfate
MI = myocardial infarction (heart attack)
MRI = magnetic resonance imaging (scan)
MRN = medical record number
MRSA = methicillin-resistant staph aureus (ARM)
MSO4 = morphine sulfate
Na+ = sodium
NaCl = sodium chloride (saline, salt)
NaHCO3- = sodium bicarbonate (bicarb)
neb = nebulizer (HHN, breathing treatment)
NGT= nasogastric tube (nose to stomach)
NH3 = ammonia
NIBP = non-invasive blood pressure (cuff)
NIDDM= non-insulin-dependent diabetes
nml = normal
noc = night
non-STEMI* = non-ST elevated myocardial infarction (subendocardial)
NPO = nothing by mouth (L. non per os)
NS = normal saline (0.9% NaCl)
NTG = nitroglycerin
O.D. = overdose
OOB = out of bed
OOC = out of control
OG = orogastric (mouth to stomach)
O & P = ova and parasites (intestinal worms)
O2 = oxygen
O.T. = occupational therapy (ADL’s)
\( \tilde{p} \) = post (after) (written with a horizontal line over the top)
PA = pulmonary artery
pacer = cardiac pacemaker
paCO2 = carbon dioxide in ABG
paO2 = oxygen in ABG
PA & lat = posterior, anterior, and lateral (2-view chest)
PALS* = pediatric advanced life support
PAWP = pulmonary artery wedge pressure
PCA = patient-controlled analgesia
PCXR = portable chest x-ray
PE = pulmonary embolism (blood clot)
PEG* = percutaneous endoscopic gastrostomy (G-tube)
pH = acid-base balance (potential of hydrogen)
PICC* (“pick”) = peripherally-inserted central catheter (IV)
plts = platelets (hematology)
p.o. = by mouth (per os)
post op = post-operatively
PRBC’s = packed red blood cells (blood transfusion)
P.T. = physical therapy (exercise, activity)
PT/INR = prothrombin time/ International normalized ratio (coags)
PT/PTT = prothrombin time/partial thromboplastin time (coags)
pulse ox = pulse oximetry (oxygen saturation, O2 sat, SpO2)
PVD = peripheral vascular disease
QD = every day
QID = four times a day
QOD = every other day
quad = quadriplegic (paralyzed)
RCA = right coronary artery (heart)
re: = regarding
RF = renal failure
RFA = right forearm (RUE)
RUE = right upper extremity (arm)
RLE = right lower extremity (leg)
RLL = right lower lobe (lung)
RLQ = right lower quadrant (abdomen)
RML = right middle lobe (lung)
R/O = rule out
R.T. = respiratory therapy
R/T = related to
Rt. = routine
RUL = right upper lobe (lung)
ṣ = without (written with a horizontal line over the top)
sat = oxygen saturation (SpO2)
SBO = small bowel obstruction
SBP = systolic blood pressure (top number)
SCD = sequential compression device
SL = sublingual (under the tongue)
S.L. = saline lock (IV)
SpO2 = oxygen saturation; sat (peripheral; pulse ox)
SQ = subcutaneous (injection)
Chapter 5: BLS Lesson Plan

All nursing personnel are required to obtain and maintain CPR certification. This is a sample lesson plan that uses the content of a CPR class, and adapts authentic materials for the ESP classroom. This is good practice for other required courses, such as Pediatric Advanced Life Support (PALS) and Advanced Cardiac Life Support (ACLS). Students can engage in communicative tasks and practice performing hands-on skills. They will need practice listening to lectures and taking multiple choice tests in English if they wish to study nursing or other healthcare occupations.
**Teachers:** The format of this lesson plan contains some of the elements of the lesson plan template presented in the introduction, such as an Effective Instructional Sequence (EIS) and behavioral objectives. There is a list of possible materials to use within the plan. Language forms and functions include, but are not limited to, requesting, answering, exchanging information, describing, commanding, summarizing, informing, using wh- questions, and sequencing.

**Students:** Get a CPR, ACLS, PALS, or first aid handbook at a used book store or library to study independently.

**BASIC LIFE SUPPORT (BLS) ESL LESSON PLAN**

The following material is adapted from the American Heart Association *BLS for Healthcare Providers* (2001). It is not intended to be used as official CPR instructional material, or in an actual BLS certification course, but rather as an introduction to the English language used in such a setting, and as preparation for actual BLS instruction. This is an example only of a CPR lesson plan for an ESL/ESP setting.

**Goals:**
- The students will use English in selected scenarios they will encounter in an authentic CPR course.
- The students will experience the process of CPR instruction and certification via practical and written exams.
- The students will engage in communicative activities related to medical emergencies, using the English language.

**Level:** beginning to intermediate English.

**Language Functions:** answer questions, ask, command, describe, provide information, request, state, summarize.

**Objectives (by the end of this lesson):**
1. Learners will determine the responsiveness of a victim by asking, “Are you OK?”
2. Learners will obtain assistance from bystanders by calling out, “Help! Someone call 911.”
3. Learners will demonstrate how to locate a defibrillator by asking bystanders, “Do you have an AED?”
4. Learners will correctly label five parts of anatomical illustration: head, mouth, airway, heart, lungs.
5. Learners will correctly state what the letters “A, B, C, D” stand for in the context of a medical emergency.
6. Learners will correctly state what the letters “CPR” stand for.
7. Learners will organize initial CPR steps into correct sequence.
8. Learners will demonstrate how to call 911 and state type of emergency: medical, fire, or crime.
9. Learners will demonstrate how to state the location of emergency (number and street, cross street) to a 911 dispatcher over the telephone.
10. Learners will answer questions concerning absence or presence of breathing and pulse in a victim.

Materials:

“Official” CPR/BLS supplies include items such as specially-designed mannequins, face masks, barrier devices, oxygen tubing, bag-valve masks, and AED’s, as well as pre-printed tests, and instructional videos. This lesson plan depicts a “warm-up” session, to acquaint learners with the language and scenarios they will encounter in a real CPR/BLS class. As a simulation of CPR procedure, everyday items can be imaginatively employed for use in instruction. But first, as this is an adult victim, and not a child or infant BLS practice, it should be made clear to students that they are resuscitating an adult. Infant/child CPR differs in technique. Therefore, it is best not to use dolls or props that would imply an infant/child victim. Large dolls or large stuffed animals would work. Instructor could display pictures of a child/infant, and an adult, and use a marker pen to ‘x’ out the infant picture, while stating, “this is not child or infant CPR; it is for adults” while pointing to the adult picture.

The dummy: a large doll, or teddy bear; large pillows for the torso; a Styrofoam wig stand for the head; a pumpkin for the head; drawings of the arms with spots designated for radial pulse checks; papier-mâché constructions, etc.

The equipment: a soft rubber ball, partially deflated, or a balloon, to squeeze as a bag-valve mask device; stickers to use as EKG leads; larger stickers to use as AED pads.

The phone, EMS: toys, such as an ambulance, police car, fire truck; telephone, real or toy, and phone book; pictures from magazines, etc.

The diagrams/illustrations: pictures from magazines glued to poster board, prepared anatomy charts, anatomy textbooks, homemade drawings, etc.

Vocabulary:

Anatomical nouns: airway, back, carotid artery, chest, chin, C-spine, elbows, epiglottis, esophagus, femoral artery, hand, head, heart, heel of hand, jaw, lungs, mouth, neck, nose, pharynx, radial artery, sternum, stomach, throat, tongue, trachea, ziphoid process.

Verbs/imperatives: activate, apply, ask, assess, attempt, call, check, compress, continue, count, deliver, describe, determine, feel, give, listen, locate, lock, look, maintain, observe, open, pinch, , place, practice, produce, provide, push, reassess, reattempt, reposition, resume, return, scan shock, tap, try, touch, tell, use, watch.
Wh-questions: How many people? What happened? What is your emergency? What is your location? What is your name? What is your phone number? When did it happen? Where are you? Who is injured?

Other terms: adult, air escaping, air movement, arrest, blood flow, breathing, cardiac arrest, carotid pulse, chest pain, chest expansion, circulation, collapse, cyanosis, defibrillation, difficulty breathing, does not have a pulse, exhalation, fall down, femoral pulse, flow of air, has a pulse, heartbeat, heart rate, inhalation, injury, lack of oxygen, loss of consciousness, not breathing, palpable pulse, pass out, pulse, radial pulse, rescue breathing, respirations, respiratory arrest, stop breathing, suspected trauma, un-witnessed arrest, ventilation, witnessed arrest.

algorithm = a set of steps used in diagnosing and treating a disease (see Taber’s p.70).

A,B,C,D = airway, breathing, circulation, defibrillation.
ACS = acute coronary syndrome.
BLS = basic life support.
CPR = cardiopulmonary resuscitation.
EMS = emergency medical services.

CPR sequence:

Employ universal precautions and demonstrate effective infection control techniques during patient care situations. Use gloves, goggles, and barrier devices if available. Of course, these may not always be available in the field. Demonstrate proper handwashing. Encourage students not to place their mouths in direct contact with the dolls/dummies; disposable plastic can be used to cover the dolls’ faces and changed between students. Clean all reusable plastic items with bleach. Supply hand sanitizer and disinfectant wipes.

A – Airway. Establish unresponsiveness. Are you OK? Tap shoulder. Call for help. Is the victim breathing? Open the airway: head tilt-chin lift maneuver; for suspected trauma: neck immobilization with jaw thrust only. Place your ear near the victim’s mouth and nose, observe the victim’s chest. Look, listen, and feel for breathing. Feel for the flow of air approximately 10 seconds. Give two rescue breaths. Watch for visible chest expansion. Reposition head, if necessary. Listen for air escaping during exhalation.

B – Breathing. Is the victim breathing? Is there a pulse? Make chest visibly rise with each ventilation. Pinch nose to prevent air escaping. If attempts to ventilate are unsuccessful, reposition head and reattempt rescue breathing. Use a barrier device if available. Use a bag-valve mask if available. Place in recovery position if breathing resumes, and victim has a pulse.

C – Circulation. Check for pulse, scan for movement approximately 10 seconds. Palpate carotid pulse on neck next to trachea, use gentle pressure, and don’t use thumb (because you may feel your own pulse). Perform compressions fast and deep, 100/min. 15:2 ratio (15 compressions for every 2 breaths). Use the heel of your hand, on the lower half of sternum, avoiding the ziphoid process. Lock your elbows, push straight down, using
weight of your body. For an adult victim, the depth of compressions should be 1.5-2 inches. Use compression force that generates a palpable carotid or femoral pulse. Allow the chest to return to its normal position after each compression.

D – Defibrillation.
Obtain an automated external defibrillator (AED) unit. Turn on the machine. A voice will say, “Apply pads” (usually the voice of Peter Thomas. You may recognize his voice as the narrator for the television show Forensic Files). Apply pads to the victim’s chest. Machine will say, “Do not touch the patient. Analyzing rhythm.” Do not touch or ventilate the patient while the machine is analyzing. The machine will say, “Shock advised.” or “no shock advised.” If a shock is advised, press the button to deliver a shock. The machine will instruct you to continue CPR or stand clear to administer another shock. Continue CPR, (breathing and compressions) for one full minute, and reassess the patient.

An Effective Instructional Sequence (EIS):

1.) Setting the Stage:
This step in the sequence serves to motivate learners, capture their interest, tap into prior knowledge, and anticipate future learning.

To introduce the topic and capture students’ attention, you can play a video depicting a medical emergency and the interventions of bystanders. This could be an authentic CPR course video, a clip from a television show or film, or a homemade video. Another option is to act out the scene as a skit for the class, demonstrating what the students will be doing. All materials should be displayed, and you can tell the students what they will be learning and doing. Some learners may recognize the situation and know terms in their own language, but need help translating messages into English. For others, the situation may be relatively new.

2.) Comprehensible Input:
This step in the sequence serves to present the new material. It should be visually rich and contain frequent comprehension checks. Comprehension can be checked by asking yes/no questions in the target language, based on the material being taught, and have students respond. Learners can be asked questions wherein they must choose between two or more objects, and pick the one that is being described. A technique can be demonstrated, and the students asked if it is correct or incorrect. Allow the learners processing time, and repeat questions several times. If at first there is no response, try to re-phrase the questions, or use a different approach.

Vocabulary can be presented with posters of anatomical diagrams, the ABC’s of life support, CPR sequence, etc. Total Physical Response (TPR) techniques can be used with commands such as “open the airway,” “look, listen and feel for breathing,” “check for a
pulse,” etc. Photos of different people depicting actions such as clutching their chests, lying unconscious, lying next to a fallen bicycle, etc., can be shown, and the instructor can ask the learners, “what’s wrong with this person?” The instructor can describe the scene and what type of emergency it is.

3.) Guided Practice:

This step in the sequence involves skill-getting. Activities should be contextualized and meaningful, and help students internalize the new material.

The instructor can demonstrate assessment of a victim and steps in the CPR sequence. The instructor can place written test questions on an overhead projector, reading each question and its accompanying answers aloud, and modeling the process of choosing the one best answer. Students can work in pairs practicing one-person and two-person CPR on a practice dummy or doll. Students can practice labeling anatomical diagrams. Students can create flashcards of pertinent vocabulary with index cards and pens or crayons, and quiz each other by pointing to the items on diagrams, or physically acting out the word.

4.) Application and Extension:

This step in the sequence involves skill-using, allowing students to generate their own language.

Students can perform CPR on dummies, or act out skits involving a medical emergency. A list of steps can be used as a checklist for students to observe each other while they practice. In groups, students can study and discuss written test questions.

5.) Evaluation:

This step in the sequence allows students to demonstrate what they have learned.

Students can physically demonstrate the steps of CPR, and verbally describe their actions. Students can take a multiple choice test that simulates a real CPR course written test. Students can take quizzes composed of cloze questions (fill-in-the-blanks), matching, and labeling diagrams.

**Practice CPR/BLS multiple choice exam.** Choose the one best answer.

1. A 55 year old man collapses in front of you. You determine unresponsiveness, have someone call 911, and feel no pulse. When you attempt initial rescue breathing, you are unable to ventilate. What action should you take next?
   a. give abdominal thrusts
   b. reposition the head, open the airway, and try to ventilate again.
2. A 65 year old man with a known history of coronary disease complains of chest pressure and pain radiating up into his jaw and down his left arm. What is the most likely cause of his symptoms?
   a. acute coronary syndrome (ACS)
   b. acute CVA
   c. ventricular fibrillation
   d. cardiac arrest

3. Once CPR is started, when should you reassess the victim?
   a. every 30 seconds
   b. after 4 complete cycles of CPR, and every few minutes thereafter
   c. only if the victim wakes up
   d. every 60 seconds

4. What do the letters CPR stand for?
   a. coronary pressure resistance
   b. call, perform, respond
   c. compression-palpation ratio
   d. cardiopulmonary resuscitation

5. What is the rate of chest compressions in adult CPR?
   a. 60/min.
   b. 200/min.
   c. 100/min.
   d. 120/min.

Answer key: 1. b; 2. a; 3. b; 4. d; 5. c.

**Communicative tasks: Calling 911**

Exercises and activities involving the following material can take place in steps three, four, or five of the EIS. The purpose of this activity is to give students practice in using the language, and to help fulfill objectives eight, nine, and ten. Prepare pictures from magazines or homemade drawings depicting scenes of fire, automobile accidents, injuries, medical emergencies, etc. Gather toys such as dolls, trucks, bicycles, animals, trees, ambulances, police cars, etc., as well as telephones, to use as props. Create index cards with a telephone number, address, and nearest intersection written on each card. (Make each card different, and indicate whether the phone number is for a cell phone or
“land” line). Use poster board, index cards, or construction paper to create question cards with a scene depicted on one side, and the description of the scene on the back of the card. Prepare and display three pieces of poster board or construction with the words “fire, medical, or crime” on them, or write these three words on the board as three separate categories. Introduce the topic: “Today we are going to practice calling 911.” Display the 911 page of the local phonebook. Outline steps in the sequence by writing them on the board, or by displaying a prepared poster. The students will read and listen.

**Practice calling 911 (steps in the sequence):**

1. Assess the scene.
2. Call 911.
3. Answer dispatcher’s questions.
4. What is your emergency?
   a) **Medical:** car accident, man down, fall, sick, choking, stroke, seizure, injury.
   b) **Fire:** flames, smoke; building, car, grass, trees, an explosion.
   c) **Crime:** people fighting, guns, dangerous driving; property damage, theft, problem with
      1. animals.
5. How many people?
6. Where are you?
7. What is your telephone number? Cell phone or land line?
8. Do not hang up. Follow dispatcher’s instructions.

Read each of the steps aloud, and describe them using body language and props to indicate what is involved in each step. Use prepared scenes and props to depict the type of emergencies, and have the whole class help you categorize them as fire, medical, or crime. Students (as a whole class) can categorize pictures under headings fire, medical, or crime per instructor’s questions. Wh-questions of who, what, and where can be incorporated into comprehension checks. Use the cards with addresses and phone numbers to read answers to numbers six and seven of the steps. Students will listen, read, and speak, answering questions. Allow students to become familiar with the material. Have the students look through the cards, and handle the toys and props.

Ask the students to form pairs. Create a list of directions.

1. “**Ask your partner to describe the scene.**”

Distribute cards with scenes on one side, and descriptions on the reverse side, to the pairs. Allow students to practice together. One student will hold up a card with the scene facing the other student. The student looking at the picture will practice describing the scene. The other student can help with prompts as needed. Partners then switch roles. (Or the
instructor can call out “switch” after allotted time frame, five or ten minutes, depending on the rate of students’ progress).

2. “Location.”

Have the students form pairs with a different partner. Distribute cards with fictitious addresses and phone numbers on them to the pairs of students. Another card will have these questions on it, “Where are you? What is the nearest cross street or intersection? What is your phone number?” Have the students use the cards to quiz each other, then switch roles.

3. “A 911 Transcript.”

Distribute a copy of the “script” to each student. The instructor can read the whole script aloud to the class, perhaps displaying it on an overhead projector. Then the whole class can read it aloud together. Ask students to switch partners again. Direct each student to assume the persona of each character, asking and answering questions, then switch roles. Students can use information on prepared cards to answer questions or improvise. Skills involved in these activities are listening, speaking, and reading. Functions include asking, answering, and describing.

As a follow-up activity, hold a general class discussion about the activity, and allow students to share personal experiences or ask any questions they may have. Then review the steps in the sequence with the whole class. Remind the students to give the location of their emergency: address, cross street, nearest intersection. Remind the students to use a regular phone when available (land line) rather than a cell phone, so that dispatch can trace the location more easily.

Students can perform a skit in front of the class for additional practice.

**Example transcript:**

**Dispatcher:** 911, what is your emergency?
**Caller:** a) medical: someone is hurt; there is a car accident; a man/woman down; animal is attacking a person. b) fire: there is smoke/fire; a building or grass/plants; explosion. c) crime: people are fighting; dangerous driving; there is a gun; property damaged; theft; problem with animals.
**Dispatcher:** How many people? Is he/she breathing? Does he/she have a pulse? Do you know CPR? Is he/she bleeding? How old is he/she? Any signs of trauma, like broken bones, a fall, or hit by a car?
**Caller:** (describe the problem). He/she is not breathing. He/she does not have a pulse. I’m attempting CPR. He/she is a mature man/woman.
**Dispatcher:** Where are you? What is your address? What is your location?
**Caller:** I’m at _______ (number and street). The cross street is _______. The closest intersection is _______.
DISPATCHER: What is your telephone number and your name? Are you calling from a cell phone?
CALLER: My number is xxx-xxx-xxxx. My name is _______. Yes, it is a cell phone.
DISPATCHER: Help is on the way; do not hang up. (Follow dispatcher’s instructions).

Chapter 6: Medical Transcription Templates

Transcription: The physician (doctor) dictates (speaks) the progress note into a phone (message is recorded). A transcriptionist (typist) listens and transcribes (types) it. In this section are formats nurses may find when reading physicians’ progress notes. This material is good for practicing listening, finding key information, and answering questions. The nurse may need to locate information while someone is waiting on the phone, for example. Possible questions include “what did his chest x-ray show?,” “what does the EKG show?,” “is this acute or chronic?,” “does he/she have any allergies?,” “when was he/she admitted?” Language forms and functions include asking, informing, describing, responding, exchanging information, wh- questions, past tense, and passives. This is the language of medicine, which includes the patient history, physician’s assessment, diagnosis, treatment, and evaluation.

Teachers: Possible classroom exercises include listening for key information. Documents can be used for cloze or sequencing exercises. Students can listen and attempt to transcribe what they hear. Authentic tape recordings would be best, but very difficult to utilize without violating HIPAA laws. The teacher can read a prepared note several times, or make a tape recording in advance and replay it as many times as needed. Students can then check their comprehension by reading a copy of the actual note, following along while the teacher reads the piece aloud one final time. For materials, charts can be assembled from binders, paper, dividers, and clipboards. Any and all medical and nursing reference texts should be handy. Authentic documents are optimal, but must not contain any patient identifiers, physician names or signatures.

Students: The physicians’ progress notes are where you can find information about the patient.

Practice answering these types of questions: when was his/her surgery? What does his/her chest x-ray show? Is the atrial fibrillation new or chronic? Who did the surgery? Who admitted him/her? Why did he/she come to the hospital? Was he/she taking this medication at home? Does he/she have a history of high blood pressure? Is he/she allergic to any medications? Think about where you would look in the chart to find answers.

MEDICAL TRANSCRIPTION TEMPLATES

The following outlines represent commonly-encountered formats for physicians’ dictated and transcribed notes. The list is not intended to be exhaustive or applicable to all health care facilities or situations. These outlines may be helpful to the nurse in finding specific patient-care related information in the chart among the physicians’ progress notes.
**History and Physical (H & P).** The physician’s assessment of the patient may contain:

- **Present illness:** why the patient came to the hospital.
- **Current medications:** names, dosages, and frequencies.
- **Past medical history (hx):** surgeries, illnesses, hospitalizations, etc.
- **Allergies:** a list of the patient’s allergies, or NKA (*no known allergies*).
- **Social history (hx):** information about the patient’s occupation, lifestyle, and marital status.
- **Family history (hx):** what the patient’s parents and siblings died from, or suffered from.
- **Review of systems:** a physical assessment of the patient.
- **Laboratory data:** test results thus far.
- **Diagnosis (dx) or impression:** current problems.
- **Plan:** treatments ordered.

**Radiology (x-ray).** A radiologist’s report may contain:

- **Views submitted:** type of pictures, scans, etc.
- **Radiological findings:** what the radiologist sees.
- **Impressions:** what the radiologist thinks it indicates.
- **Recommendations:** other tests (diagnostics) to further investigate or confirm findings.

**Operative Report** (surgery note). A surgeon’s report may contain:

- **Name of primary surgeon and assistants.**
- **Date and type of surgery performed, and type of anesthesia administered.**
- **Procedures performed and description of each.**
- **Estimated blood loss; specimens removed.**
- **Post operative diagnosis.**

**Physician’s Progress Note.** A physician’s progress note may follow this pattern:

- **Subjective data (information from pt.):** “I hurt all over.”
- **Objective data (what can be seen, measured):** labs, I&O, test results, ABG’s, CXR, etc.
- **Assessment:** appearance, heart rhythm, lung sounds, bowel sounds, etc.
- **Condition of level of progress:** the patient’s response to treatment.
- **Conclusions:** current problems, plan.

**Discharge Summary.** A physician’s discharge summary may include:

- **History of present illness.**
- **Past medical history.**
- **Medications, allergies.**
- **Review of systems.**
- **Impression, plan, hospital course and treatment.**
- **Disposition.**
Chapter 7: Nursing Diagnosis

This section deals with the written language of nursing, specifically, the nursing process and care plans. One acronym is sometimes used to list the steps of gathering data and developing a plan: SOAPIE. This refers to subjective data, objective data, assessment, planning, implementation, and evaluation. This sequence can also be used to organize nurses’ charting.

One definition of the nursing process is presented here, plus a list of steps in that process. In nursing school, students will be introduced to the North American Nursing Diagnosis Association (NANDA) Taxonomy II, which provides a list of approved nursing diagnoses. There is a three-part format for writing nursing diagnoses which consists of a patient problem, its etiology, and signs and symptoms that provide evidence for the problem. This is the language of the nursing care plan, and it is one component of nursing school and clinical care. Questions regarding this material may also appear on the NCLEX exam.

Teachers: Language forms and functions include, but are not limited to, the future tense, naming, describing, explaining, cause and effect relationships, and evaluating. Possibilities for classroom activities include practice writing nursing care plans, and identifying and correcting language errors in existing plans, to ensure that they adhere to the NANDA format. Materials needed are any and all available medical and nursing textbooks, Taber’s and/or a nursing diagnosis handbook. An overhead projector with transparencies can help instructor and students “work out” their plans together, with the instructor modeling the writing style.

Students: practice writing nursing care plans for these medical disorders: congestive heart failure (CHF), pneumonia, acute myocardial infarction (MI), acute cerebrovascular accident (CVA), fractured hip, pulmonary emboli (PE), small bowel obstruction (SBO). Identify at least three problems for each condition.

NURSING DIAGNOSIS

When approaching patient care, it is necessary to sketch out a plan or blueprint as a guide.

The first step is to find out what the patient’s unmet needs are, and how to meet those needs.

Documentation helps to ensure that a plan is followed, and if it is effective. Specialized language is used in this documentation. The unmet needs, in the nursing spectrum, are patient problems, stated as nursing diagnoses. Steps taken to meet those needs are interventions. The whole cycle of activities is called the nursing process. “The nursing process is a deliberate, problem-solving approach to meeting the health care and nursing needs of patients. It involves assessment (data collection), nursing diagnosis, planning,
implementation, and evaluation, with subsequent modifications used as feedback mechanisms that promote the resolution of the nursing diagnoses” (Nettina, 2006, p. 5).

Steps in the nursing process:

1. **Assessment**: “systematic collection of data to determine the patient’s health status and to identify any actual or potential health problems.”
2. **Nursing diagnosis**: “identification of actual or potential health problems that are amenable to resolution by nursing actions.”
3. **Planning**: “development of goals and a care plan designed to assist the patient in resolving the nursing diagnoses.”
4. **Implementation**: “actualization of the care plan through nursing interventions or supervision of others engaged in nursing interventions.”
5. **Evaluation**: “determination of the patient’s responses to the nursing interventions and of the extent to which the goals have been achieved” (Nettina, 2006, p. 5). Nurses study and are licensed to treat the patient’s response to illness and medical treatment.

A nursing diagnosis is composed of specialized language. An approved list of nursing diagnoses is the NANDA Taxonomy II; state nursing diagnoses based on the NANDA list. (See Taber’s Appendix, “Nursing Diagnoses”). It is important to be systematic in the approach, and use only approved nursing diagnoses. There is a three-part format for writing nursing diagnoses and care plans which consists of a problem (P), the cause of the problem, or its etiology (E), and the signs and symptoms (S) or evidence of the problem. So the three-part statement looks like this:

(P): Patient problem ______ (nursing diagnosis, see NANDA Taxonomy II)
(E): Related to (R/T) _______ (etiology, cause of above problem)
(S): As evidenced by (AEB) ______ (signs, symptoms (S/S), physical evidence).

**Example**: (P) Impaired Skin Integrity (E) related to bedrest (S) as evidenced by reddened skin on coccyx.

Some abbreviations used in the writing of patient care plans are:

- AEB = as evidenced by
- etiology = cause
- NANDA = North American Nursing Diagnosis Association
- PES = problem, etiology, symptoms
- R/T = related to
- S/S = signs and symptoms
- formula for nursing diagnosis = PES: problem ___, R/T ___, AEB ___.
- NANDA Taxonomy II = list of approved nursing diagnoses
dx = diagnosis
There are many books on this subject, in addition to the nursing appendix in Taber’s. Many hospital units will have handbooks, as well as pre-printed nursing care plans to study and use.

Reference pages:

American Nurses Association (ANA): www.nursingworld.org (requires membership)
Care Plans.com www.careplans.com (requires membership)

NANDA (North American Nursing Diagnosis Association): www.nanda.org (requires membership)

NCLEX-RN (National Council Licensure Examination for Registered Nurses): see National Council of State Boards of Nursing (NCSBN) www.ncsbn.org

Nurse Practice Act: see individual State Boards of Nursing

RN Central.com: www.rncentral.com – free and available nursing care plans/formats!!
Quan, K. (2007-9). The Nursing Process. www.thenursingsite.com/Articles - free and available source for many types of nursing information!!

Taber’s Cyclopedic Medical Dictionary: Appendix, “Nursing Diagnoses.”

Chapter 8: HIPAA, Patient Rights, DPAHC

This section provides an introduction to the administrative language of policies and procedures, rules and regulations, and legal dimensions of nursing practice. Various state and federal organizations are involved with the business of healthcare, such as OSHA (the Occupational Safety and Health Administration), and individual state boards of nursing. Each state board has its own Nurse Practice Act. Nurses are required to adhere to their particular institution’s policies and procedures in the delivery of patient care. The first rule of patient care is to do no harm, and workers must be aware of what actions would constitute physical and/or emotional jeopardy of the patient. Institutions educate staff regarding HIPAA (Health Insurance Portability and Accountability Act) laws and protected patient information, and violators will be penalized. A list of patient rights is usually displayed on a wall for public access. As part of the admission process, patients are usually asked if they have a designated durable power of attorney for healthcare (DPAHC).

Part of nursing work requires teaching patients about their care, what medications they are taking, etc. Nurses also function as patient advocates. It’s important to reassure students that they will not have to memorize all of this material, but just become familiar with it. Nursing responsibilities include knowing how to access a facility’s policies and procedures, follow the proper chain of command, and direct patients and their family
members to appropriate resources. There are usually social workers and discharge planning nurses available to assist with patient healthcare and insurance issues and to provide access to resources. This is the language of the legal system and government institutions; questions related to these topics may appear on the NCLEX exam.

**Teachers:** Possibilities for classroom activities include role-plays that help students answer patient questions and explore the legal and ethical dimensions of nursing. Information could be presented in a PowerPoint presentation as a seminar, with a multiple choice quiz to assess comprehension. Authentic materials would be best, such as textbooks, copies of the Nurse Practice Act, employee handbooks, copies of policies and procedures, etc.

**Students:** Locate your facility’s policies and procedures, and read through them. Create a glossary of words that are new to you.

**HIPAA**

All patient information is private and confidential, and no part of the medical record or health information can be released to a third party without the patient’s consent. The following is a brief description of some of the elements of the HIPAA Privacy Rule, taken from the U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR):

“The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. The Privacy Rule standards address the use and disclosure of individuals’ health information—called “protected health information” by organizations subject to the Privacy Rule—called “covered entities,” as well as standards for individuals’ privacy rights to understand and control how their health information is used. The privacy rule protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information “protected health information (PHI). A major goal of the Privacy Rule is to assure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public’s health and well being” (p. 1). This information was retrieved December, 2008 from: www.hhs.gov/ocr/privacysummary.pdf

Additional information can be found at www.hhs.gov/ocr/hipaa or OCR “Business Associate” Guidance, OCR “Government Access” Guidance.

**PATIENT RIGHTS**

In addition to the privacy rules, patients also have other rights. Many facilities will display a “Patient’s Bill of Rights” for the public to read. The following statement regarding patient rights is taken directly from the American Hospital Association (1998):
“The American Hospital Association (AHA) presents *A Patient’s Bill of Rights* with the expectation that it will contribute to more effective patient care and be supported by the hospital on behalf of the institution, its medical staff, employees, and patients. The American Hospital Association encourages health care institutions to tailor this bill of rights to their patient community by translating and/or simplifying the language of this bill of rights as may be necessary to ensure that patients and their families understand their rights and responsibilities” (p. 1).

The first in this list of twelve patient rights states, “you have the right to considerate and respectful care.” In addition to the overriding concern of high quality care in a clean and safe environment, the subsequent rights address access to information, freedom to make decisions about care and treatment, access to one’s own medical records, the right to informed consent, and the choice to refuse surgery. There are other variations on the list of patient rights for mental health services, hospice care, and individual insurance providers. Patients are encouraged to be actively involved in their health maintenance, care and treatment. The list of twelve rights concludes with this statement:

“Patients are responsible for providing information about past illnesses, hospitalization, medication, and other matters related to health status. To participate effectively in decision making, patients must be encouraged to take responsibility for requesting additional information or clarification about their health status or treatment when they do not fully understand information and instructions. Patients are also responsible for ensuring that the health care institution has a copy of their written advance directive if they have one. Patients are responsible for informing their physician and other caregivers if they anticipate problems in following prescribed treatment” (p. 3).


The following websites related to this topic are excellent and informative:

www.who.int/genomics/public/patientrights/en/  
www.cancer.org/docroot/mit/content/mit_3_2_patients_bill_of_rights.asp

**DPAHC: DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

The following information represents one legal firm’s advice on the subject of preparing a Durable Power of Attorney for Health Care (DPAHC). It is not intended to serve as an exhaustive description or official document. (See also “Living Will” and “Advanced Directives” for further information on this topic).

When patients are admitted to the hospital, they are asked by nurses and other staff members if they have a DPAHC, and if a copy is on file at the hospital. Many patients are
unfamiliar with this process. Nurses may have to briefly explain what a DPAHC is, and why it is important. One explanation provided by these authors states, “By executing a durable power of attorney for health care, you name a representative to make decisions regarding health care for you if you become incompetent. Without such a representative, your physician generally makes your health-care decisions (usually with the participation of one of your family members) unless a court formally appoints a representative for you” (p. 2). The authors advise, “Make only one person representative at a time to prevent disagreements between your representatives that may give conflicting directions to the medical professionals treating you. Some state laws require that only one representative can serve at a time for this reason” (p. 3).

It is important to inform patients that they, or their designated decision maker, must discuss their desired resuscitation status each time they are admitted to the hospital, and the physician must write an order to withhold any life-sustaining measures. In the absence of a written order, everything will be done to sustain the patient’s life. There is usually a packet containing information that the nurse can give to the patient, and the patient can be directed to speak with the physician and social services to discuss options. Nurses are not allowed to function as witnesses in the signing of legal documents in the hospital.

The authors also advise that, “You should review your DPAHC regularly, especially to ensure that it still conforms to your wishes as to the choice of representative” (p. 4).

The above information was found on this website: www.raymondjames.com/branches/c2c/35C/oxleygroupja/articles/pwere_of_attorney/healthcare.pdf

Chapter 9: Recommended Books and Websites

Here is a brief list of selected resources. The subjects include language and linguistics, teaching language and teaching of adults, culture and nursing, and English for nursing. Hopefully, these will provide some links to resources for creating AHE and ESP materials.

RECOMMENDED BOOKS AND WEBSITES

These are some personal favorites . . .

Language:


**Teaching:**

• www.cde.ca.gov
• www.actfl.org
• www.tesol.org
• www.adultedcontentstandards.ed.gov/
• www.education-world.com/standards/national/index.shtml
• www.cde.ca.gov/be/st/fr/
• www.med.fsu.edu/education/FacultyDevelopment/objectives.asp
• www.nursingassistantcentral.com

**Culture:**


**English for nursing:**

• American Heart Association *ACLS, BLS, and PALS* textbooks
• Anatomy and physiology textbooks (any)
• Medical terminology textbooks (any)
• NCLEX review books (any)
• www.thenursingsite.com
• www.rncentral.com
Chapter 10: Reader Questionnaire

The reader questionnaire has been developed to elicit feedback from students, language instructors, nursing instructors, or other members of the healthcare or educational teams. This input will be used to improve and expand upon the handbook.

READER QUESTIONNAIRE

Please offer your critique/evaluation of this handbook:

1. What is your occupation, profession, or field of study?

2. Why did you choose to read this handbook?

3. Did you discover any books or publications cited in this handbook that were new to you? Please list them and/or describe.

4. Did you find anything unique about this material compared to other nursing resources?

5. If you noticed something different, please explain.

6. Which type of organization for an ESP reference of this type do you prefer: alphabetical order, body systems, or other categories? Please explain.

7. In what ways could this material assist you in designing ESL/ESP instruction for nurses?

8. What did you like most about this material? Explain.


10. Please describe any suggestions for improvement, including any other books or materials you personally find relevant or helpful.

11. Would you recommend this material to others in this field? Why?