Language of Learning: Policy, Personal Preference, and Professional Identity

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Abstract

This article explores medical students' preference to study in English rather than their home language as an index of identity formation at the University of KwaZulu-Natal. Data were produced through interviews with 19 third-year medical students and 6 lecturers. Data were recorded, transcribed, submitted to respondents for checking, then analysed thematically using NVivo. Analysis of their class's assessment marks according to demographic characteristics was performed using SPSS. The analysis showed a statistical and sustained difference between first- and second-language English speakers. However, the latter preferred English as their medium of teaching and learning. They saw terminology as being more problematic than language, stated that their own languages did not have sufficient technical vocabulary, and felt that their professional interactions would be conducted largely in English. The author concludes that language influences, and is influenced by, an individual's identity. Professional identity is a powerful shaping force in young adulthood when one's personal identity is being de-and re-constructed. The status of English, and the developmental state of other South African languages, are also salient factors. While these findings support policies to develop the technical vocabularies of indigenous languages, they also signal the ways in which language use may be constrained by students' personal perceptions and professional goals.

Keywords: Identity, identity formation, professional identity, medical students, language, discourse, language policy.

Introduction

> The language we use forms an important part of our sense of who we are – of our identity (Edwards 2009: i).

Particularly at this point in history, South Africa's various language groups are able to assert the primacy of their own languages in multiple spheres – social, cultural, religious, and academic. The Higher Education Act of 1997 (Anonymous) mandates university councils to determine language policies, and the University of KwaZulu-Natal (UKZN) is not the only higher education institution to formulate a language policy (Anonymous 2006), not only in terms of the language(s) of teaching and learning and administration, but also in order to acquaint students with the principal indigenous language of the region (Vithal undated). Against the thrust of policies on developing indigenous languages as media of scientific discourse, can be set the proclivities of institutions, communities, and individuals who would be required to create and implement these developments. These proclivities may be influenced by the inherent inertia of resistance to change, and also by specific personal considerations such as the areas of interest to those charged with language development, and the perceptions of those subject to language policies.

This article presents findings from a mixed-methods study that explores the influence of language on higher education students' academic results, and the perceptions of students and lecturers of issues to do with language. It sets out to answer the questions:

- What is the influence of home language relative to the language of teaching and learning on students' marks?
- How do students and staff members respond to the data on marks versus home language?
- Why do these constituencies respond in the way that they do?

In order to set these questions in context, I review the literatures on identity, language, higher education, and professional identity. I then describe my methodologies for investigating these aspects in the setting of UKZN's School of Clinical Medicine. I discuss the findings that arise, and finally offer an analysis of these findings in relation to the literature.

Literature Review

Identity in General

Erikson (1980) depicts an individual's mental development as a sequence of changes, each constituting an 'identity crisis' which the individual must resolve. He makes the point, as do others, that identity formation is a lifelong progress of which the individual and the community are largely unaware. With reference to the crisis of adolescence, Erikson (1977) maintains that this is a period of 'identity confusion' (Erikson 1968:131), and explains further: 'In general it is the inability to settle on an occupational identity which most disturbs young people. To keep themselves together they temporarily over-identify with the heroes of cliques and crowds to the point of an apparently complete loss of individuality' (ibid.: 131f).

Piaget (1969) maintains that the chief characteristic of adolescence is detachment from the concrete here-and-now in favour of the potential and the future, and believes that the significance of this period of life is less that of puberty than of 'the individual's introduction into adult society' (ibid.:149). Homing in on a specific aspect, Skorikov and Vondracek (2011) describe occupational identity formation as a major element in an individual's development of meaning and structure – which they believe is a critical task of adolescence.

Burkitt (2011) contends that the individual is not born into an identity, but that one's life in particular contexts is the means by which one's identity is formed. Creuss *et al*. (2015) propose that throughout our lives we continuously organise our experiences into meaningful wholes incorporating our personal, private, public, and professional selves. They further argue (ibid.) that there are three domains of identity development relevant to (medical) education, namely individual, relational, and collective identity.

Gore and Cross (2014) suggest some of the detail of the changes that a developing or evolving identity may undergo, proposing three elements common to identity change. These are: the extent to which aspects of the self are rewarded or punished in the current environment; comparisons with others; and the cognitive accessibility of social and physical stimuli. If the audience that views the self is large, of higher status, and is made salient, the self is likely to be presented in ways deemed appropriate for that audience. Thus, for example, one may downplay one's own language at the expense of the language perceived to be ascendant. Comparing oneself with others in the

community that one aspires to enter can lead to changes in the direction of likeness. Taking medical students: the lab coat, the stethoscope draped casually around the neck, and the adoption of the discourse – and the language in which the discourse is conducted – exemplify these changes. Given that one's concept of self is to an extent a cognitive construction, as students take new cognitive information on board, so also they take on new conceptions of themselves as inhabitants of the new cognitive space.

While Piaget describes cognitive development and Erikson psychosocial development – each of which contributes to identity formation – both can be criticised for portraying human development as stepwise rather than continuous. Burkitt implies that identity is contextually formed, and both Cruess and Gore imply that parallel processes may take place continuously. For the purposes of this discussion, I take it that the process of becoming a doctor represents a significant period of change for students, which is not only perceived as such by them (Sommerville 2014), but would be recognised as salient by each of the authors cited.

Language and Identity

Bamberg *et al.* (2011: 182), writing on the intersection of the use of discourse and construction of an identity, state that:

> ...speakers, in their choices of how they say what they say ... are interpreted as making use of (indexical devices) that cue listeners on how to read their messages as interactively designed. It is through a reading of these means that hearers (or more generally, recipients) come to a reading of the speaker's intentions and ultimately to a reading of how speakers present a sense of who they are. ...

Bourdieu (1977: 652) argues that 'a language is worth what those who speak it are worth' and 'speech always owes a major part of its value to the value of the person who utters it', implying that choice of language reflects, in one sense, the values of the speaker.

Foucault (1972) describes what he terms the 'political' nature of language choice: that what is said, and *can* be said, using language, is constrained by forces beyond language. Within a body of knowledge, he argues, the discourse of that discipline is shaped by – and in turn shapes – those

who profess that discipline, and the knowledge that they profess. The disciplinary discourse may be constructed and refined so as to act as its own gatekeeper – only certain people may be granted access to the discourse and be allowed to speak through it and about it.

Foucault writes also about the role of ritual: the stance, the behaviour, the circumstances, the implicit understandings surrounding the use of discourse to signify not just the validity but the roles of speakers within the discourse. The ritual of clinical teaching – the hierarchy, the way in which patients are approached, examined, and presented to the consultant – is what Shulman (2005) identifies as the signature pedagogy of medicine. This is its characteristic mode of teaching and learning, which necessarily entails use of the technical discourse of medicine. If the discourse is available only in a particular language, use of that language becomes a necessary part of the ritual. In similar vein, Hafferty (1998) writes of medicine's hidden curriculum: that which is not explicitly taught, but which is transferred by example – elements of dress, of behaviour and, no doubt, of speech and language patterns.

Taking a critical look primarily at acquisition, rather than use, of a second language, Norton and McKinney (2011) examine this acquisition as a process of identity construction, not purely as an educational transaction. They affirm that identity is multiple rather than singular, changes over time, and contains inferences as to power dynamics in learning – and, I dare add, using – language. One of these power dynamics is access to particular communities, and investing in their cultural capital (Bourdieu 1977) by use of language.

Turning to the use of specific languages, Obanya (1995) mentions the perception in West Africa that African languages are not suited to scientific discourse. Burkitt (2011) argues, following ideas of Vygotsky and G H Mead, that language does not express pre-existing thoughts so much as provide the tools for forming thoughts. This implies that if a particular language does not contain the verbal tools to express certain thoughts, these cannot be entertained or conveyed by that language. Edwards (2009: 58) disagrees, claiming that developments in a language are secondary to conceptual advancement: 'Words themselves are only indicators'. Of course, the proficiency with which one operates in a particular language may also constrain the thoughts that one can form and convey in it.

McKinney (2007), studying black learners at schools in suburban Johannesburg, observes that proficient use of English may be a source of pride,

connoting that the speaker (and, by implication, the wider family) is educationally and/or financially well off. She does, however, note the ambivalence of township dwellers who acknowledge the value of English in accessing various benefits, but at the same time denigrate their peers whose skill in English is better than in their own language. Detractors use the terms 'coconut', 'Oreo', 'Top Deck', and 'white wanna-be' to suggest that, in neglecting the language of their peers, those who speak English better reduce – or attempt to reduce – their (racial) identity to a superficial veneer. Expressing a contrasting view (in the Western Cape) that the vernacular is not 'cool', Heugh *et al*. (2007: 104) describe a feeling among school children that isiXhosa is 'old-fashioned and used simultaneously by intellectuals and rural people.'

Ambivalence about language use is not limited to South Africa; there is an extensive literature on language attrition in other countries (Ginsberg 1986; Hyltenstam & Obler 1989; Kopke & Schmid 2002; Lambert & Freed 1982; Schecter & Bayley 1997). This attrition is seen principally amongst immigrant minorities learning the language of their adopted country and gradually, through lack of use, forgetting their own and failing to pass it on to the next generation. The learners in Johannesburg and the Western Cape quoted above are not, geographically speaking, immigrants, and other non-immigrant example exist: Native American languages, for example, have been documented as suffering the same disuse (Crawford 1996). South African indigenous languages may be under similar threat – for instance, through poor teaching by the older generation to the next (Nkosi 2011).

McKinney (2007) writes of language use as a strategic performance, as if to imply that in fact language, and its inferred identity, can be assumed or laid aside. This is echoed by Warschauer's (2001) finding that postmodern identity is 'multiple, dynamic, and conflictual, based not on a permanent sense of self but rather the choices that individuals make in different circumstances...'. One such circumstance might be assimilation into a community by acquiring and interpreting the language of the community. Wenger (1998) writes of membership of a community of practice as being only part of our identity as student, family member, and member of a religious or other interest group. He describes a community of practice as having three distinctive characteristics (Wenger undated): a commitment to a domain of practice, a community that builds relationships that enable members to learn from each other, and a shared repertoire of resources for practice. Entry into a community of practice entails learning the nature of the domain, the behaviours of the

community and the competencies of the practice, and, like all learning, this transforms our identities (Wenger 1998).

Those who write philosophically of discourse and identity may assume that the intersection of the two is played out within a uniform language structure, while those who draw from practical experience of language use may assume that a single discourse is being conducted in more than one language. For the purposes of this article, I distinguish between the *language* used by an ethnic group and the technical *discourse* used by a profession, and I argue that the use of a specific language in a particular context may signal the user's sense of identity as clearly, if not more so, than the use of the appropriate discourse.

Higher and Professional Education and Identity

Moving on to the particular time and place in which identity and language are expressed, Besser and Zeigler-Hill (2014) point out that stress at the beginning of university life tends to lower self-esteem, even in those students who exhibit positive personality characteristics such as optimism, hope and happiness. Cuperman *et al.* (2014) describe the malleability of the opinions of individuals with a weak sense of self. Diemer and Blustein (2006), following Freire's (1973) concept of critical consciousness, describe how oppressed individuals frame a critical analysis of the structures of their oppression, and of their perceived capacity to change the inequities in their socio-political circumstances. These authors then relate the agency of critical consciousness to individuals' sense of vocational identity in expressing their ability to overcome systematic stumbling blocks. Hadden *et al.* (2014), arguing from self-determination theory, posit the need to integrate self-concepts so as to fulfil three psychological needs of relatedness, competence, and autonomy. They describe presenting the self relative to others either assertively (by ingratiation, intimidation, or self-enhancement) or defensively (by self-handicapping, disclaiming failure, or self-justification).

Referencing the foregoing texts is not to suggest that students in general, or second language English-speaking students in particular, have weak, oppressed identities. What the texts do suggest, however, is

the force of influences on the young adult's sense of identity when entering an institution that has an alien tradition and culture.

In the intellectual culture of the medical school, Jarvis-Selinger *et al*. (2012) argue that development of clinical competence – medical education's current emphasis – is not itself enough to establish students as part of the community of practice. They argue that doing a doctor's work is only part of being a doctor. The role of a doctor is not the same as the identity of the individual becoming a doctor, and the process of becoming a doctor in fact involves construction and subsequent reconstruction of a number of identities, such as: scholar, student, clinical clerk, intern, independent practitioner. (Foucault might link these various roles to a sequence of 'rituals' in the discourse of medicine.)

Skorikov and Vondracek (2011), summarising research on occupational identity, find that achievement of a strong occupational identity is associated with good mental and emotional health, and that this achievement is particularly important for disadvantaged youths. In traditionally male-dominated occupations such as medicine and engineering, females – often seen as disadvantaged in those fields – tend, perhaps surprisingly, to have stronger occupational identities. This may be because of their need to assert their commitment to their career. These authors suggest further that in middle and late adolescence, the provision of mentors and role models significantly enhances occupational identity development. They make the pertinent point:

> Occupational identity refers to the conscious awareness of oneself as a worker. The process of occupational identity formation in modern societies can be difficult and stressful. However, establishing a strong, self-chosen, positive, and flexible occupational identity appears to be an important contributor to occupational success, social adaptation, and psychological well-being. ...we note that there is also an urgent need to address the issues of cross-cultural differences and interventions that have not received sufficient attention

in previous research (ibid.: 69).

It is evident that identity is a concept and a construct that develops with the individual, and is mutable according to circumstances. The literature adduced does not, however, address the philosophical question of whether each individual in fact possesses an essential core identity – an 'I *qua* myself' if you will (but see Bamberg *et al.* 2011). Identity in its development and its outworking is generally portrayed as 'I relative to others' – akin to the indigenous concept *ubuntu*; as an expressed identity. Wenger and others would argue that identity is both built and revealed in community. Certainly, languages and discourses are used in various communities in interactions between individuals. Each language is shaped by the history of its users, and, as Burkitt (2011) argues, in turn shapes its users' thought patterns. (Burkitt's drawing of an analogy with Vygotsky's theories of education is interesting, but, I suggest, incomplete: it is an individual, not a language, who aids in developing the learner's mastery of almost-in-reach material.) I argue, with Edwards (2009) – and presumably with those who champion the intellectualisation of indigenous languages (Anonymous 1997; Anonymous 2006; Captain-Hasthibeer 2015) – that developing thought patterns form the language. The need to express new concepts or name new discoveries demands new lexical terms, and it seems that the thrust of efforts to intellectualise indigenous languages appears to be aimed primarily at the vocabulary of the languages concerned.

A significant intersection of language with discourse occurs when students make the transition from high school to university. In the former they may have been taught nominally in a second language; in the latter, the majority of their lecturers and their textbooks operate in that second language alone, as they induct the students into a technical discourse. Medicine serves as an example of a discourse to be assimilated; more than a vocabulary, a repertoire of concepts.

The various literatures on identity *per se*, language, and professional education frame, but do not directly address, the topic of language change during the development of a professional identity. This

article seeks to address some of the insufficiently researched issues of cross-cultural differences in language and discourse in professional education, by means of a combination of methods as described below.

Methodology

For this study, a mixed-methods approach was adopted: a quantitative phase to measure the influence of students' languages on their assessment marks, and a qualitative phase to explore possible explanations for any effects seen.

For the quantitative analysis, the assessment marks of a cohort of students were recorded over the entirety of their five-year curriculum, in order to see if any effect found varied over time. As a matter of convenience, a class was chosen that was part-way through its course and whose marks were obtainable from the university marks system. So as to maintain consistency with regard to the class members and the assessments, students who failed a year and dropped back into a subsequent cohort were excluded from further analysis. Similarly, students from the preceding cohort who had failed a year, and thus dropped back into the cohort under study, were not included in the analysis.

Marks were collated in an Excel® spreadsheet, rendered anonymous, and imported into SPSS®. Analysis of assessment marks according to home language was performed in SPSS, using the general linear model (GLM). This is similar to analysis of variance (ANOVA) using regression (Field 2009:350), and can be regarded as the overarching term that includes comparative tests such as the t test, ANOVA and regression analysis. The GLM has the advantage of being able to incorporate matrices that represent sets of data and also to make multiple comparisons (Trochim 2006).

In their third year, 19 students from the cohort under study were purposively selected so as to represent the demographic spread of the class as to ethnicity, sex, age, previous academic experience and current academic performance. These students were interviewed in groups or individually, depending on their availability. At the same time, six members of the teaching staff, chosen to represent a spread of ethnicity, age, and clinical- or laboratory-based disciplines, were interviewed using the same semi-structured schedule. A graph showing the relationship between languages and marks over time was used as a stimulus for discussion; participants were asked to comment on what

the graph depicted and what might explain what was portrayed. Interviews were recorded, transcribed and anonymised, submitted to respondents for checking, then analysed thematically using NVivo®.

Ethics permission, gatekeepers' assent and participants' informed written consent were obtained prior to commencing the study.

Findings

In a class of 202 students, 15 different languages were spoken as mother-tongue, including 91 first-language English speakers and 65 first-language isiZulu speakers. Statistical comparison between the 15 language groups over time showed no consistent relationship: $p = 0.145$ on ANOVA according to GLM. Categorising marks into two groups – English first or second language – showed a significant ($p = 0.001$) difference of about 6% in favour of first language English speakers, which was maintained over the whole period of their degree programme.

In the interviews, the aspect of language cropped up in discussions on the nature of the barrier between everyday knowledge and medical knowledge, as well as specifically relating to the marks differences referred to above. In this article I am focussing on the responses to my question 'Would you prefer it if we were to lecture and assess you, and provide textbooks, in isiZulu (as the dominant vernacular)?' To my surprise, the answer from isiZulu speakers and non-speakers alike was uniformly 'No!' Reasons given for this response can be grouped broadly into factors pushing away from isiZulu, and those pulling towards English.

(Quotes are identified by pseudonyms and line numbers in the interview transcriptions.)

A not unexpected attitude to the local indigenous language was typically expressed:

> *…if you dare to speak English … [patients] are so offended. Like you think … English is the, it's the better language. It's the language of the white persons that oppressed the black people, so now 'You think you're better'* (Zodwa;658-60).

Such a reaction would be unsurprising in virtually any setting; apart from the sensibilities of the patients, one's pride in one's own language is an understand-

ably strong sentiment.

One student toyed briefly with the idea of being taught in isiZulu:

> *…it will help, I think, receiving lectures and notes in Zulu, because it would make it better. But like I've got this point: at the same time it would take us back to the whole '94 apartheid thingie – and then we – I don't think it's going to help much* (Imbali:760-2).

Imbali's response harks back to the days of 'separate development' when discrimination in terms of the language of instruction was a sore point (Anonymous undated). It is noteworthy that, so many years later, the suggestion of separation according to language elicited an adverse reaction.

Considerations more practical than political were also raised:

> *People who are coming from Durban and Pietermaritzburg are speaking a more easier form of Zulu, unlike people that are coming from Nkandla that are speaking the Zulu that the chief speaks – you know – and it's different…* (Zodwa; 693-5).

Students from urban centres recognised that their command of their own language was deficient compared to that of their rural-origin peers. This deficiency extended to technical terminology:

> *…it makes it worse. Do you know how to put Zulu into medical Zulu? We'll spend a decade on one system. … So putting it in Zulu – it actually takes you two steps back…* (Lungi; 597-8).

> *…in terms of understanding, you know, the concepts, sometimes, ja, the terminology can not be – easy* (S'bu; 593-4).

The problematic matter of terminology was also mentioned by an isiZulu-speaking staff member:

> *…putting the instruction into Zulu wouldn't have made any change to me. In fact, it would have made it more difficult for me, because how would you translate 'pancreatitis' into Zulu…* (Dr Hlubi; 137-9).

At the same time as negative connotations of studying in isiZulu were expressed, reasons were given for the use of English:

> *English is one of the country's – one of the languages that you need to know and understand* (Lungi; 625-6).

> *…in terms of medical, medical language and medical jargon, when you speak to someone in Cape Town, you speak to someone in Jo'burg about a patient here, you have to understand each other* (S'bu; 590-2).

In parallel with Imbali's reluctance to return to the days of separate education, a similar thought was expressed in slightly different terms by another student:

> *I think there has to be some kind of universal idea with the whole thing, because then some people are learning in Zulu, some in English, and they are stuck to what they learn in and they cannot converse with each other now, in terms of peer relationships and doctors* (Bala; 749-51).

There was generally a sense that English and the local vernacular could co-exist. An isiZulu member of staff was comfortable with his isiZulu-speaking students greeting him and talking amongst themselves in that language. However, their presentations of patients' cases were invariably in English:

> *As I walk around, you can hear them speaking to one another in Zulu, discussing the case. But when they come to present at the end of ten minutes, fifteen minutes, they present in English…* (Dr Hlubi; 121-3).

Despite a demonstrable and persistent difference in assessment marks between first- and second-language English speakers, the latter consistently argued for continuing in English, citing both reasons against using isiZulu and for using English.

Discussion

The quantitative data that acted as a stimulus for discussion show a disparity between the absence of statistical significance when comparing all 15

languages with one another, set against the significance when comparing English first-language speakers with English second-language speakers. This may be due partly to the fact that some languages were spoken by few students, making statistical significance less likely due to the low numbers. In contrast, seeking common features between groups, in order to form larger aggregates which may be more likely to reflect statistical significance, is a statistical technique that, in this instance, was able to confirm the impression that first-language English speakers have the advantage in English-medium education.

It is not possible to claim that studying for a profession is the sole impulse that drives students seemingly to reject their mother tongue. The pervasiveness of English in schooling, in the media, and in social life generally (Jensen, Arnett & McKenzie 2011), could account for its ascendancy in students' minds. However, given the (theoretical) offer of the opportunity to study in the language(s) in which they were most at home, and bearing in mind that their patients would expect them to communicate in the vernacular(s), it is nevertheless striking that they should unanimously opt for English as their preferred medium of learning. This implies that there may be stronger forces at work than the pervasive presence of English in their lives, when it comes to choosing a language for professional communication.

Erikson and others (Cruess *et al.* 2015; Erikson 1977; Piaget & Inhelder 1969; Skorikov & Vondracek 2011) describe the ferment of identity development in the adolescent phase of finding an occupational identity. Given that language and its use are related to construction and expression of the user's identity (Bamberg *et al.* 2011; Edwards 2009; McKinney 2007; Norton & McKinney 2011), and that entry into a profession is mediated, at least in part, by acquisition of its discourse (Foucault 1972; Shulman 2005; Wenger 1998), I argue that my respondents' choice of English as their preferred language of teaching and learning springs from their emergent professional identity, rather than from a rejection of their mother tongues. Erikson (1968) writes, as noted previously, of the tendency to over-identify with the heroes of the moment. My student respondents showed no signs of hero-worship of their teachers – although Erikson (ibid.: 129) also recounts adolescents' 'loud and cynical' concealment of any such commitment. I suggest that identification with their role models in the medical world, all of whom use English professionally, may well be part of the loosening of students' ties to the languages that were hitherto so much a part of their identities.

Without entering into the debate about whether language follows or forms the development of thought patterns (Burkitt 2011; Edwards 2009; Obanya 1995), my English second-language respondents certainly reflected the fact that certain technical terms and concepts current in the community they were joining were not available in their own languages. Respondents commented that one of the barriers they faced on entering medical studies was the technical terminology. This was available to them only in English, the language and discourse thus presenting a double hurdle. (Possibly unique to this country is the fact that for some students, English may have been their third or fourth language. The problem of operating in a language not their own remains, nonetheless.)

Shulman (2005) identifies clinical interaction as the signature pedagogy of medicine; the ritual, in Foucault's (1972) terms, that signals the status of those who engage in its discourse. The discourse, and thus the language in which the discourse is conducted, is a part of the ritual. Staff and student conversations in their own language (isiZulu) signify their comfort with that aspect of their identities; their automatic transition to English for the formal case presentation signifies their acceptance of the ritual of the medical practitioner identity. It is interesting, bearing in mind the instances of ambivalence to one's own language cited above (Heugh *et al.* 2007; McKinney 2007), that several of my respondents proclaimed their own township origins, and admitted that they were unable to speak correct isiZulu as spoken in rural areas. Dr Hlubi's observation in his wards that students talked amongst themselves, and casually with him, in isiZulu, yet presented patients formally in English, perhaps corresponds to the mutable use of language depending upon circumstances as related by Warschauer (2001).

My respondents saw their access to the medical community as mediated (partially, not wholly) by a particular language. The dynamics of power and time (Bourdieu 1977; McKinney 2007) were touched on by Imbali, who accepted that learning in her own language would be good, but rejected the idea because it smacked of the past days of 'separate development'. At that time, language was one of the distinctions used by those in power to discriminate against certain groups of people – 'identity as a site of struggle' (Bourdieu 1977: 74) indeed!

As to the site of higher education, Besser and Zeigler-Hill (2014) describe the stress experienced by students entering university life. How much more might this be the case for those labouring under the various disadvantages

affecting many present-day South African students, whose state of mind may be less sanguine, and whose self-esteem less robust, than that of students in culturally more homogeneous countries? My respondents did not in fact exhibit the typical features of malleability of opinion that Cuperman *et al.* (2014) describe in individuals with a weak sense of self. I suggest that it is not a weak self-image but rather the stresses of a significant change in intellectual environment that may have brought these students to the point of appearing, at medical school, to abandon their own language in favour of another.

My respondents, both students and staff members, could be thought of, in Hadden's (2014) terms, as 'ingratiating', insomuch as their peers and superiors, and this researcher, habitually speak English. On the other hand, respondents may have been exercising self-enhancement by asserting their ability to cope in a second language. Thus, by autonomously choosing to operate in English, and proclaiming their competence in that language, they established their relatedness to other practitioners in the field. Noels *et al*. (1996), writing from Canada, which has a strong bilingual tradition, observed Chinese-speaking university students, noting that they tended to identify themselves exclusively with either the Chinese or English languages. I find the comparison with my own students intriguing, considering the extent to which the latter code-switch in practice, while maintaining that their primary allegiance in their studies is to English.

One is always aware of the risk of bias when interacting with one's own students – the more so in the area of language. As might be expected, the language in which an interview is conducted tends to produce responses in the frame of the culture represented by that language (Smith 2011). Thus, being questioned in English – the language of the individualistic Western culture – respondents would be more likely to provide answers that accorded with that culture, since these individuals themselves come from a culture that values consensus and agreement.

Respondents' interactions with me as researcher were relatively limited. However, medical students and staff members are generally in daily contact. Dr Hlubi's comment on students' language use in his ward illustrates part of the 'hidden curriculum' (Hafferty 1998) that implicitly teaches students their role as doctors-to-be. Dr Hlubi, as a role model, may inadvertently perpetuate the stereotype of the practitioner who dresses in a certain way, behaves in a certain way, interacts with patients in a certain way, and addresses colleagues *in a certain language*. As students strive to mould themselves into

the role to which they aspire, just as linguistically they pick up the discourse of medicine, so too they pick up with it the language in which they see the role portrayed.

It is quite apparent, from Dr Hlubi's observations in his ward, that isiZulu-speaking students were not abandoning their own language. By the same token, my argument is not that they were in a phase of discarding their linguistic and cultural identities, but that they were in the process of constructing a new and additional professional identity as one of the multiple identities that each individual negotiates for him- or herself (Creuss *et al.* 2015; Norton & McKinney 2011; McKinney 2007; Warschauer 2001; Wenger 1998).

Conclusion

I have sought, relative to a synthesis of the literature on the topics of language and identity, to establish that the initially surprising choice of English as academic language by respondents for whom it was not their first language stemmed more from their efforts to construct an occupational identity that reflected the profession for which they were studying than from an abnegation of their own languages and their ethnic and personal identities.

The bias induced by a non-representative sample is inherent in qualitative methodology, and, as mentioned above, my posing of questions in English may also have influenced respondents' replies. The consistency of the responses, particularly in the face of a significant and sustained academic advantage in favour of those assessed in their home language, suggests that the thoughts expressed were both valid and genuine. The exact nature of their reluctance to use their own languages could be a fruitful area of further study.

Policies for language use may be formulated to serve political ends (such as enhancing the status of indigenous languages) and/or educational needs (such as the enhancement of students' epistemic access to higher education). Taking a more pragmatic point of view, clinical medicine has the need to communicate effectively with patients, which requires the learning of local languages – itself a difficult task (Matthews & van Wyk 2015). Intellectualisation of indigenous languages, in terms of devising technical vocabularies and discourses for the crafts, technologies and professions that South Africa needs, is a laudable aim. I imagine that my respondents would support such an initiative. It would address some of the 'push factors' that at present militate against the use of vernacular languages at this level of study.

Having said that, I acknowledge that posing the question of first-language teaching presupposes an immense amount of work in producing the resources (technical vocabulary, textbooks, lecture notes, examination questions, and marking rubrics, among other necessities) that such provision would require. The unavailability of such resources in this place at this time – and thus the hollowness of the question – may well have influenced my respondents' answers. When implementing educational language policies, care will be needed in dealing with the 'pull factors' that promote the use of English as an increasingly global language, and, by the same token, the 'push factor' of students' diminishing competence in their mother tongues, rendering problematic both their understanding of their own language and their grasp of technical discourses in that language.

This article presents a cross-cultural, mixed-method study that contributes to the need expressed by Skorikov and Vondracek (2011) to address cross-cultural differences and interventions that have not previously been sufficiently studied.

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