ISSN E: 2709-8273
ISSN P:2709-8265
JOURNAL OF APPLIED LINGUISTICS AND TESOL
JALT

ENGLISH ORAL COMMUNICATION NEEDS, LANGUAGE ANXIETY, AND CURRICULUM INADEQUACY IN PAKISTANI UNDERGRADUATE HEALTHCARE EDUCATION: A CONVERGENT MIXED-METHODS NEEDS ANALYSIS

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ABSTRACT
It is argued in the present study that Pakistani undergraduate healthcare students enter clinical practice with critically inadequate English oral communication competence, and that the formal curriculum nominally designed to address this deficit systematically fails to do so. A convergent mixed-methods needs analysis was conducted with 200 undergraduate healthcare students and 20 ESL instructors at two PMDC-recognised medical institutions in Lahore, employing five instruments: the Student Needs and Communication Questionnaire (SNCQ), the Instructor Perception Survey (IPS), the Student Semi-Structured Interview Guide (SSIG), the Instructor Semi-Structured Interview Guide (ISIG), and the Document Analysis Protocol (DAP). The findings indicate that speaking for patient communication was rated as the most severely underdeveloped skill (M=2.35/5.0), while patient history-taking (M=4.70/5.0) and clinical case presentation (M=4.68/5.0) were simultaneously rated as the two most critical professional competences. Furthermore, language anxiety was found to be pervasive and clinically significant (M=39.5/50), suggesting that an anxiety-avoidance cycle operates systematically across both institutions. Document analysis likewise confirmed that oral assessment accounts for an average of 2% of total ENG-251 assessment and 0% of ENG-253 assessment across five institutions, indicating a profound misalignment between curriculum provision and professional communicative demands. Similarly, ESL instructors confirmed these deficiencies with analytical precision, identifying class size, written assessment dominance, and cultural irrelevance of materials as the three structural barriers to communicative instruction. In a nut shell, the study establishes that the communicative deficit is not a consequence of individual student inadequacy but a structural consequence of curriculum and assessment design, and provides a multi-instrument empirical foundation for targeted intervention.

Keywords: *English for Specific Purposes, needs analysis, healthcare communication, language anxiety, Pakistani medical education, oral communication competence, ESL, curriculum design*

1. INTRODUCTION

English in Pakistani healthcare education occupies a structurally contradictory position. It is simultaneously the mandatory medium of the medical curriculum, the lingua franca of the international clinical literature, the prescribed language of patient documentation, and the threshold language of postgraduate examinations that determine professional careers. Yet most students enter healthcare programmes from schooling systems in which English was taught as a written grammar subject and assessed through pen-and-paper tests, never as a living medium of professional communication (Rahman, 2002; Shamim, 2024). This contradiction produces a gap that is both ubiquitous and consequential, inasmuch as students who can parse a sentence and write an essay freeze when required to present a clinical case in English, struggle to explain a diagnosis to a patient, and carry unaddressed language anxiety into their clinical practice.

The Higher Education Commission (HEC) mandates two English language courses, Functional English-I (ENG-251) and Expository Writing (ENG-253), in the undergraduate curricula of all affiliated Pakistani medical institutions. It is worth noting, however, that the policy commitment is genuine while its execution is inadequate. These courses were not designed for healthcare professionals. Their prescribed learning outcomes specify grammatical

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accuracy, paragraph organisation, and academic essay writing, all written competences, assessed entirely through written tests. Consequently, the document analysis conducted in this study confirms that across five participating institutions, oral communication appears as a specified learning outcome at no institution and accounts for an average of 2% of total course assessment. In this regard, a curriculum that does not assess speaking tends not to develop speaking, because students direct their effort rationally toward what determines their grades (Nomaan, 2022).

Prior studies of English communication challenges in Pakistani healthcare contexts (Rashid et al., 2017; Bhati et al., 2023; Imran et al., 2023) have established the existence of a communication gap through small-sample qualitative research or single-institution surveys. The present study addresses the limitations of prior work by employing a five-instrument, two-institution, convergent mixed-methods design that generates triangulated evidence from quantitative surveys, qualitative interviews, and systematic document analysis simultaneously. The study is structured around two research questions: (1) What are the English communication needs and language anxiety profiles of undergraduate healthcare students at Pakistani medical institutions? and (2) What are the perceptions of ESL instructors regarding student communication challenges, teaching constraints, and MALL adoption readiness?

2. THEORETICAL FRAMEWORK

The study is grounded in Hutchinson and Waters's (1987) target-situation needs analysis framework, which distinguishes between necessities (what the learner must know to function in the target situation), lacks (the gap between current competence and target performance), and wants (what the learner believes they need). This tripartite distinction structures the SNCQ design and the analytical integration of student and instructor data. Krashen's (1982) affective filter hypothesis provides the theoretical lens for interpreting the language anxiety data, inasmuch as it proposes that anxiety, low motivation, and low self-confidence constitute a cognitive barrier that prevents comprehensible input from being processed as acquisitional material, even when it is linguistically accessible.

Macintyre and Gardner's (1994) anxiety-competence model establishes the bidirectional relationship between language anxiety and communicative competence that is central to the interpretive framework of this study. The model proposes that anxiety reduces the cognitive resources available for language processing, thereby impairing communicative performance; impaired performance, in turn, confirms the anxious learner's beliefs about their own inadequacy, thereby amplifying anxiety. This self-reinforcing cycle, which the present study documents empirically, is the primary target of any effective communicative intervention for this population. Ladson-Billings's (1995) framework of culturally relevant pedagogy is additionally invoked to interpret the cultural irrelevance findings from the document analysis and instructor interviews, on the grounds that materials whose cultural context learners do not recognise impose an additional cognitive load that competes with the language acquisition the task is intended to produce (Sweller, 1988).

3. METHODOLOGY

3.1 Research Design

A convergent parallel mixed-methods design (Creswell and Plano Clark, 2018) was employed, in which quantitative and qualitative data were collected concurrently, analysed independently, and integrated at the interpretation stage. This design was selected because the research questions require both the statistical precision of survey data and the interpretive depth of interview data, and because convergence across independently analysed strands provides triangulated validity that neither strand alone can achieve.

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3.2 Participants

The student sample (N=200) was drawn from Shalamar Medical and Dental College (SMDC, Lahore) and Lahore Medical and Dental College (LMDC, Lahore), both PMDC-recognised private medical institutions, through stratified random sampling by programme type: MBBS (38%), Nursing (31%), Allied Health (20%), and DPT (11%). Twenty ESL instructors from the two participating institutions were recruited through purposive sampling. Semi-structured interviews were conducted with a subset of twenty students and ten instructors. Document analysis was applied to ENG-251 and ENG-253 syllabi from five institutions, with the two participating institutions supplemented by three additional institutions to strengthen generalisability.

3.3 Instruments

The Student Needs and Communication Questionnaire (SNCQ) is a 45-item self-report instrument assessing perceived English skill levels (Section B, 5 items), professional communication task priorities (Section C, 12 items), language anxiety (Section D, 10 items adapted from the Foreign Language Classroom Anxiety Scale, Horwitz et al., 1986), technology access (Section E, 8 items), and MALL attitudes (Section F, 12 items). The Instructor Perception Survey (IPS) is a parallel 40-item instrument assessing instructor perceptions of student challenges, current teaching practices, curriculum adequacy, and technology adoption. The SSIG and ISIG provided semi-structured protocols for individual interviews lasting 45 to 60 minutes. The Document Analysis Protocol (DAP) examined five dimensions of curriculum alignment: communicative orientation of learning outcomes, healthcare content specificity, assessment diversity, pedagogical approach, and learner engagement and authenticity.

3.4 Data Analysis

Quantitative data were analysed using SPSS 27. Descriptive statistics were computed for all SNCQ and IPS items and sub-scale scores. Independent samples t-tests were used to compare SMDC and LMDC student profiles, with Cohen's d reported as the effect size measure. Qualitative data were analysed using Braun and Clarke's (2006) reflexive thematic analysis framework through NVivo 12. Document analysis data were scored on five-point rating scales for each DAP dimension, with a score of 3.0 constituting the adequate threshold. Mixed-methods integration was achieved through a joint display matrix identifying convergences and divergences across all five instruments.

4. FINDINGS

4.1 Student Needs Profile (SNCQ)

All five English skill domains fall below the scale midpoint of 3.0 at LMDC; four of five fall below midpoint at SMDC. Speaking for patient communication is the most severely underdeveloped skill at both institutions (SMDC: M=2.48; LMDC: M=2.21; combined M=2.35), followed by medical vocabulary (M=2.65). Only reading comprehension at SMDC marginally exceeds the adequate threshold (M=3.42). The Perceived Skills Index differs significantly between institutions ($t(198)=2.12$, $p=.036$, $d=0.37$), with SMDC students rating themselves modestly more competent, which is consistent with their higher proportion of English-medium private school graduates (53.8% versus 37.5% at LMDC).

The professional communication needs priority ranking reveals a clear hierarchy in which all five tasks rated as critical (mean above 4.0) involve oral production: patient history-taking (M=4.70), clinical case presentation (M=4.68), interprofessional handover (M=4.55), patient counselling (M=4.43), and explaining diagnoses (M=4.38). Research paper writing is ranked lowest (M=3.58). Furthermore, the alignment between what students rate as most important and what they rate as their weakest competence, both pointing to oral professional

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communication, defines the intervention rationale with precision that requires no supplementary argument.

Language anxiety is pervasive and clinically significant across both institutions. The combined MFLCAS-adapted total anxiety score is M=39.5/50, above the clinical significance threshold of 37.5/50 established by Horwitz et al. (1986). LMDC students score significantly higher than SMDC students (M=41.0 vs. M=38.2; t(198)=2.54, p=.013, d=0.45), consistent with their higher proportion of Urdu-medium school graduates. Sub-scale analysis reveals that items relating to speaking in front of senior clinical staff generate the highest anxiety ratings at both institutions (SMDC: D4=4.21, D5=4.18; LMDC: D4=4.45, D5=4.41), while items relating to private written language use generate the lowest ratings. This pattern is directly consistent with the avoidance mechanism described by MacIntyre and Gardner (1994), inasmuch as high anxiety about public speaking produces avoidance of speaking practice, which in turn maintains the low proficiency that sustains the anxiety.

Technology access is near-universal: smartphone ownership stands at 97%. On the other hand, 20% of students own low-end Android devices, and 38% report unreliable internet connectivity, making offline functionality a structural equity requirement. All twelve Section F MALL attitude items exceed M=3.80. Offline access (M=4.60) and private AI-assisted practice (M=4.53) receive the highest endorsement, confirming that students actively support the design features most directly relevant to their documented access constraints.

4.2 Instructor Perceptions (IPS and ISIG)

All twenty participating instructors hold MA-level or higher qualifications in English or Applied Linguistics; none holds a postgraduate qualification specifically in ESP or healthcare communication. Sixty percent teach sections of 80 or more students, a structural constraint identified unanimously by ISIG participants as the primary barrier to communicative instruction. Instructor perceptions of student challenges are consistent with the student-side picture: clinical settings expose communication gaps not visible in the classroom (M=4.56), students struggle most with spoken English in professional contexts (M=4.50), and language anxiety is behaviourally observable during teaching (M=4.44).

All five curriculum adequacy items receive means between 1.45 and 2.00, in the strong disagreement range with the proposition that the curriculum is adequate. Item D6, whether instructors would redesign the curriculum if empowered to do so, receives the highest mean in the entire IPS (M=4.81). Likewise, a technology-attitudes paradox characterises the instructor data: MALL adoption willingness is high (M=4.40) and belief in its potential is genuine (M=4.30), but current technology use is low (M=2.54) and technology training is severely inadequate (M=1.75). This conditional-adoption profile, high willingness paired with low preparedness, has direct implications for any MALL implementation strategy, inasmuch as it indicates that training rather than persuasion is the primary implementation requirement.

The ISIG data produce ten themes, four raised by all ten participants: structural constraints as the primary barrier, grammar-focused teaching as the institutionalised default, absence of systematic oral instruction, and the curriculum-clinical gap. One instructor articulates the structural paradox with notable precision: "I know what good language teaching looks like. I have done my MA, I have read the literature, I know about communicative language teaching and task-based approaches. But my reality is 100 students, one room, one hour, twice a week. What am I supposed to do?" [TI-SMDC-4, 11 years experience]. The cultural irrelevance of materials theme (n=8/10) documents the specific mechanism through which commercially available materials fail in this context: not vocabulary difficulty or grammatical complexity, but contextual unfamiliarity that prevents students from deploying their clinical knowledge in service of the language task.

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4.3 Document Analysis (DAP)

The DAP was applied to ENG-251 and ENG-253 syllabi from five institutions. No institution reaches the adequate threshold (3.0) on any of the five DAP dimensions. On Dimension 1 (Communicative Orientation of Learning Outcomes), the highest individual score is 2.4, at an institution whose ENG-251 syllabus includes the phrase oral communication among its general aims but specifies no oral learning outcomes, no oral tasks, and no oral assessment. On Dimension 2 (Healthcare Content Specificity), the mean score across both courses and all five institutions is 1.3. On Dimension 3 (Assessment Diversity), oral assessment accounts for a mean of 2% of ENG-251 assessment weighting and 0% of ENG-253 assessment weighting across all five institutions. Moreover, these figures are not outliers produced by one or two institutions; they are consistent across all five participating institutions, which suggests a systemic norm rather than exceptional practice.

5. DISCUSSION

The convergence of findings across all five instruments on two central conclusions warrants their statement as findings rather than trends. First, speaking for professional communication is the most severely underdeveloped English skill among Pakistani undergraduate healthcare students, and the oral communication tasks that require that skill are simultaneously rated as the most professionally critical. Second, the ENG-251 and ENG-253 curricula are structurally inadequate to develop this competence because they do not assess it, do not specify it as a learning outcome, and do not provide contextually appropriate instructional content for it. These conclusions are independently validated by student questionnaire data, instructor survey data, student interview data, instructor interview data, and document analysis. This multi-source convergence substantially reduces the risk that either finding is a methodological artefact.

The anxiety findings carry implications that extend beyond the communicative domain. Rashid et al. (2017) and Bhati et al. (2023) document specific clinical pathways through which language anxiety in healthcare communication produces patient harm risk: misdiagnosis through incomplete history-taking, treatment errors through misunderstood instructions, and reduced information density in case presentations. The present study documents anxiety at clinically significant levels across both institutions, and the SSIG data confirm that avoidance strategies, including positioning at the back of ward rounds and defaulting to Urdu in formally English-medium consultations, are already operative. Consequently, the communication deficit identified here is not merely an educational concern; it is a patient safety concern that the current curriculum is producing and perpetuating.

The institutional comparison between SMDC and LMDC is itself analytically significant, inasmuch as it establishes that the communication gap is not idiosyncratic to one institution but is a structural feature of Pakistani private medical education, with its dimensions varying predictably as a function of students' prior schooling background. Students from Urdu-medium government schools report significantly lower speaking competence, significantly higher language anxiety, and significantly greater discrepancy between professional task criticality and personal communicative capacity. On the other hand, this finding argues against individual or institutional remediation as the appropriate response and in favour of structural curriculum reform.

6. CONCLUSIONS AND IMPLICATIONS

This study provides the first multi-instrument, multi-institution empirical documentation of English oral communication needs, language anxiety, and curriculum inadequacy in Pakistani undergraduate healthcare education. The findings indicate that the communicative deficit is structural, that it is clinically consequential, and that it is remediable through targeted intervention. Three implications follow directly. For HEC curriculum policy,

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the learning outcome specifications of ENG-251 and ENG-253 are indicated to require reform to include explicit, measurable oral communication competences and a mandatory minimum oral assessment component. For institutional administrators, the structural conditions that prevent communicative instruction, class size, assessment design, and material selection, constitute the primary targets for reform rather than instructor professional development alone. For ESP researchers and module designers, the twelve-point needs profile produced by this study's convergent Phase 1 analysis constitutes a validated specification for the design of a mobile-assisted English language teaching intervention for Pakistani healthcare students.

Limitations of the study include geographic restriction to Lahore-based private PMDC-recognised institutions, which constrains generalisation to public institutions and non-Punjab provinces where Urdu-medium schooling is more prevalent and English proficiency at university entry is correspondingly lower. The self-report basis of the student and instructor survey data is subject to the standard limitations of perceived competence measures. Future research is recommended to replicate this needs analysis in public medical institutions and in provinces other than Punjab, and to employ performance-based measures of oral communicative competence alongside self-report measures.

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