A GENRE-BASED APPROACH IN ESP CLASSES TO TEACHING CLINICAL COMMUNICATION FOCUSING ON BREAKING BAD NEWS TO PATIENTS

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Abstract

Healthcare professionals have the responsibility to regularly convey difficult information such as unfavourable diagnoses, as well as adverse treatment outcomes. While this task can be uncomfortable, successfully carrying it out plays a crucial role in determining patient outcomes (Sweeney et al. 2011: 230). This necessity has led to the creation of evidence-based protocols such as SPIKES developed by Baile et al. (2000). The goal of the paper is to explore the suitability of the genre-based approach for the study and teaching of medical English, focusing on the integration of the selected clinical communication tool into the ESP classroom. As this study stems from the ESP practitioner's experience and its outcomes will directly influence her future ESP classroom teaching, action research has been conducted. The feasibility of using an authentic clinical tool in an ESP lesson was assessed through a two-step methodology: i) devising an ESP task based on the SPIKES protocol, emphasizing linguistic elements, and ii) obtaining student feedback focusing on the perceived usefulness of the tool. Overall, the collected data indicate that students acknowledged the significance of effective clinical communication for successful therapeutic practice. However, given the fact that medical English is inconveniently scheduled in a pre-clinical phase of their curriculum, they also exhibited a certain level of hesitancy, unsurprisingly, when it came to readiness in handling serious communication scenarios.

Keywords

medical English, medical oral genre, delivering bad news, clinical communication, action research, ESP lesson, student survey, mediation

1 Introduction

The key aspects of the teaching of English for Specific Purposes (ESP) are to respect and develop the learner's foreign language interests and needs within the context and for the purposes of their specific discipline (Hutchinson & Waters 1987: 8). Among the many features of ESP is "discourse (rhetorical) analysis", paying attention to the special meaning that words and sentences acquire in different situational contexts (ibid.: 33-34) or genres whose mastery seems to be the prerequisite for successful practice in the given professional field.

Oral medical discourse has long been established as a discourse in its own right which has attracted the attention of linguists (Ainsworth-Vaugh 2001,

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Fleischman 2001), doctors (Baile et al. 2000) as well as antrophologists (Wilce 2009). The analysis of specific written genres in ESP is well established, but communicative purpose and strategies (Bhatia 1991) are equally present in oral genres as their participants – the doctor and the patient – utilize their own communication intentions and strategies. Additionally, during a medical encounter, the doctors follow a stage-driven (Have 1989) or moves-driven (Swales 1990) protocol, which results in the discourse being "ritualized" on the part of the doctor but still exhibiting a certain degree of unpredictability on the part of the patient (Ainsworth-Vaugh 2001: 454).

While numerous studies have examined the effectiveness of clinical communication tools, there is a scarcity of research focusing on the translation of these tools into the medical English classroom. The current study was motivated by this knowledge gap. Its research objective is to investigate the effectiveness of the genre-based approach in the study and teaching of medical English, with a focus on integrating the selected clinical communication tool into the ESP classroom. The study was conducted at Masaryk University Language Centre in Brno, Czech Republic, during medical English instruction to first-year students of general medicine at the Faculty of Medicine.

2 Medical oral genres with a focus on the use of mediation strategies

A genre is a set of communicative events that share the same goal (Swales 1990: 45-46). Identifying a shared communication goal naturally filters out utterances that potentially divert from achieving that goal in terms of content as well as style (ibid.: 52, 58). This is one of the reasons why the doctor part of the scenarios or protocols tends to be routinized. Another important feature of oral medical genres is their terminology-rich content corresponding to the purpose of the communication event (ibid.: 55). This is why selected aspects of the ESP course under examination in this paper commence by introducing a pre-genre activity in which a doctor introduces themselves to a patient, encompassing detailed elements such as obtaining the patient's preferred form of address. Following this, four genres are explored in the course: taking a patient's history, giving a diagnosis, encouraging a patient to make a health behaviour change (e.g. stop smoking) or giving a patient bad news of a terminal diagnosis, the last of which will be elaborated on in the following sections of the present text. The persuasive discourse (ibid.: 42) employed by the doctor has the so-called "double generative capacity", i.e. it both establishes communicative goals and supports their fulfilment (ibid.: 44-45), e.g. helping the patient to lose weight.

The presence of persuasive discourse underscores the need for doctors to move beyond merely conveying information to becoming intermediaries between

patients and their new diagnoses. From a linguistic perspective, the doctor's role involves 'mediation' (Council of Europe 2020: 90), which includes the introduction of daunting concepts such as a fatal disease to a patient. It is not only crucial that the patient comprehends the unfavourable message communicated but also that they can integrate it into their personal and professional lives, make informed decisions about treatment options, and actively pursue them. Therefore, the doctor must employ language to create "the space and conditions for communicating," "construct new meaning", and convey "new information in an appropriate form" within the professional, specifically clinical, context (ibid.: 90). Healthcare professionals need to employ "mediation strategies", such as connecting to prior (patient) knowledge, adjusting (medical) terminology, and simplifying complex information (ibid.: 90). They must assist the patient in processing both the emotional and factual aspects of the encounter and plan the next steps in their treatment. The steps involved in delivering bad news, along with examples of language that enhances the effectiveness of the interaction, are detailed in the following section.

3 SPIKES, an authentic protocol developed based on clinical practice data

Based on extensive research which, among other things, showed doctors' apprehension in delivering bad news, Baile et al. (2000) developed a six-step protocol for giving unfavourable diagnoses to cancer patients in order to increase doctor confidence during these complex encounters. The six-step protocol acronymized as SPIKES, refers to the main stages of a clinical communication encounter from the doctor's perspective: "setting up the interview", "assessing the patient's perception", "obtaining the patient's invitation", "giving knowledge", "addressing the patient's emotions" and "strategy and summary" (ibid.: 305-306, 308). In applying the SPIKES protocol the doctor aims to achieve four principal goals: i) eliciting information from the patient, ii) communicating medical information to the patient, iii) offering assistance to the patient, and iv) encouraging the patient to cooperate with the doctor to choose a treatment option (ibid.: 302). The value of following the SPIKES protocol in clinical communication has been extensively examined and found overwhelmingly positive by numerous studies, as indicated by Mahendiran et al.'s (2023) review study. Similarly, it has served as an inspiration for the creation of innovative protocols (Narayanan et al. 2010, Von Blanckenburg et al. 2020, Meitar & Karnieli-Miller 2021). However, it is noteworthy that, according to Mahendiran et al.'s (2023) recent study, the examined papers tended to measure the learner's (i.e. the giver of the news) satisfaction rather than that of the recipient, leaving a valuable research niche for future investigators in the area of the impact of clinical communication on patient

outcomes. Nonetheless, since delivering unfavourable diagnoses is perceived as a stressful task for medical doctors, examining their level of satisfaction constitutes a research objective in its own right.

In what follows, I focus on the individual steps of the protocol, which serves as the key document in the situational genre of delivering bad news to the patient. The doctor's competent use of language in each stage is essential for the successful attainment of the above-mentioned four goals. Naturally, the comparison between Swales's model and Baile's clinical protocol is only tentative, primarily undertaken to establish common ground between the realms of ESP and the specific discipline under consideration. Nonetheless, certain overlaps emerge. The initial overlap involves setting the stage by summarizing known information within the particular research area or health issue for the patient. Subsequently, there is an identification of the unknown, be it for the academic readership or the patient. Ultimately, the process concludes with an attempt to address the unknown or a new challenge, whether it be filling knowledge gaps within the academic community or proposing treatment options to the patient.

Examples of typical utterances are provided which are essential for the doctor's successful achievement of the clinical communication goals. All doctor-to-patient phrases are enclosed in quotation marks. The phrases lacking a quoted source have been conveniently generated using the OpenAI model ChatGPT (2023) and their relevance verified by the article's author. The rest have been extracted from literature, with the relevant sources cited.

Step 1: Setting up the interview (The names of the six steps were taken from Baile et al. 2000: 305-308)

s previously mentioned, the first step of the protocol corresponds to Move 1 in the rhetorical structure of the genre. In the clinical context, the primary focus is on the physical arrangement of the room (e.g. ensuring that the patient is seated), the doctor creating an atmosphere of undivided attention for the interview and using various non-verbal cues (e.g. maintaining eye-contact with the patient). The verbal interaction is intentionally restrained, with the doctor introducing themselves, clarifying their role in the patient's case, and outlining the primary purpose of the consultation. Additionally, the doctor should ensure the patient feels at ease and is prepared to receive potentially life-changing information. This phase may involve typical utterances such as:

> *"Hello, I'm Dr White, and I'm here to discuss the CT scan results with you."*
> *"Is there anybody in the waiting room who you would like to be here as I give you the information?"*

Step 2: Assessing the patient's perception

Since the patient might have incomplete, inaccurate or completely wrong information, it is imperative for the doctor to ascertain the patient's existing knowledge about their condition and their emotional response to it. This establishes a foundation for communication based on the patient's comprehension level. The typical open-ended questions would include:

> *"What is your sense of how you are doing?"*
> *"How worried are you?"*
> (examples taken from Morgans & Schapira 2015: 948)

> *"What have you been told about your medical situation so far?"*
> *"What is your undestanding of the reasons we did the MRI test?"*
> (examples taken from Baile et al. 2000: 306)

Step 3: Obtaining the patient's invitation

Patients vary in their preferences regarding the timing and extent of information disclosure concerning their diagnosis, treatment options, or prognosis. Some individuals prefer to receive all the information at once, while others prefer a gradual disclosure, often in the presence of their loved ones. Additionally, certain patients, particularly those in advanced stages of the disease, may opt not to be informed at all (Baile et al. 2000: 306).

> *"How would you like me to give you the information about the test results? Would you like me to give you all the information or sketch out the results and spend more time discussing the treatment plan?"*
> (examples taken from Baile et al. 2000: 306)

> *"How much detail would you like me to go into?"*
> *"Is there anything you would not prefer to be told?"*

Step 4: Giving knowledge and information to the patient

Here the doctor is well advised to use hedging to signal to the patient the nature of the forthcoming information.

> *"Unfortunately, I've got some bad news to tell you."*
> *"I am sorry to tell you that… "*
> (examples taken from Baile et al. 2000: 306)

To successfully accomplish this stage, it is crucial for the doctor to make sure the patient comprehends the conveyed information. The following statements might be employed:

"This might be a bit shocking, do you follow what I am saying?"
"Could you just tell me in general terms what I have been saying, to check I've explained it clearly?"

During this phase, when the doctor is actually delivering a diagnosis to the patient, it is strongly recommended to abandon medical jargon and communicate in straightforward, everyday English. In the field of oncology, this would mean using terms like "spread" instead of "metastasized" or "sample of tissue" in lieu of "biopsy" (ibid.: 306).

Step 5: Addressing the patient's emotions with empathic responses

Once the doctor has observed and possibly identified the primary patient emotion, they can offer emphatic statements ("*I can see how upsetting this is to you.*" or "*I was also hoping for a better result.*") or pose exploratory questions in response to the first patient reaction after processing the initial shock ("*Could you explain what you mean?*", "*Now, you said you were concerned about your children. Tell me more.*") (all four examples taken from Baile et al. 2000: 307). In this phase, it is crucial for the doctors to make an effort to empathize with the patient's perspective and verbally validate their feelings.

"I can understand how you felt that way."
"Many other patients have had a similar experience."
(examples taken from Bailey et al. 2000: 307)

To convey to the patient that their occasionally unfiltered comments have not only been understood but also valued, doctors are encouraged to express gratitude for their openness or honesty (Morgans & Shapira 2015: 949). Given that patients come from diverse professional and social backgrounds, they may employ their own language to evaluate their odds of survival, their determination to adhere to the treatment plan, or even the contemplation of death. It is for this reason that doctors should be familiar with colloquial or idiomatic expressions of the day (see point 4 in 4.1 below).

Step 6: Strategy and summary

In this phase, the doctor has an opportunity to see whether the preceding five stages have been effectively navigated. Additionally, they can also inform the patient of the next step.

"What is important for you in the time we have ahead?"
"OK, let's schedule the next appointment right away."

Throughout the protocol, the doctor follows the individual moves in the rhetorical structure of the genre, signalling transitions between them with signposting phrases to organize information and facilitate processing by the patient. To adapt to the needs of patients and create shared understanding, doctors engage in the linguistic process of reformulation and employ interpersonal strategies to communicate effectively, as illustrated by the phrases included within each stage. On a general level, to effectively execute the oral genre under examination, the doctor should demonstrate a high degree of fluency and intelligibility, employing proper stress and intonation patterns. They should be capable of simplifying complex terms and procedures, presenting them in a language that the patient can not only understand but also act upon. Furthermore, they should demonstrate active listening skills and be attuned to patient cues. By adhering to the protocol structure, doctors provide structure to the interview, increasing its objectivity and predictability for their patients.

4 Methods and data

As previously mentioned, the feasibility of integrating an authentic clinical tool into an ESP lesson was assessed using a two-step methodology: i) development of an ESP task based on the SPIKES protocol, with a focus on linguistic elements, ii) collection of student feedback following the lesson, focusing on the perceived usefulness of the tool.

4.1 Devising an ESP lesson

In order to translate the medical communication genre into a viable lesson plan, the following steps needed to be taken. Firstly, the rhetorical structure of the genre of delivering bad news was identified, utilizing as the key document the above-mentioned evidence-based protocol (Baile et al. 2000). Secondly, the language means applied in each step of the protocol were determined. Thirdly and finally, the key aspects of the lesson during which first-year medical students are exposed to the linguistic features of the genre were outlined, followed by student participation in a relevant role-play designed as a low-fidelity or low-authenticity simulation. This approach aligns with the current trend in medical education, which emphasizes the use of simulation techniques. The term fidelity refers to the event's ability to replicate real-life situations. In a high-fidelity simulation, for instance, the replication is so precise that even a trained healthcare professional may find it challenging to distinguish the simulated event from an actual one.[1] What follows are the six key stages of the lesson in question.

1) Firstly, students are introduced to the topic through two warm-up activities. In the initial activity, they are presented with six situational scenarios (see Figure 1) and asked to select the one they perceive as the most challenging when breaking bad news to a patient. They are encouraged to explain their choice in the context of other cases. In the second activity, students collaborate in small groups in order to identify and discuss reasons why doctors often find it difficult to deliver adverse news. Some of these reasons include a lack of proper training in communicating bad news, the fear of causing emotional distress to the patient, and the apprehension of being blamed by the patient for the distressing information. By engaging in these activities, students are expected to gain valuable insights into the complexities and emotional aspects involved in delivering negative news, helping them develop the necessary skills and empathy needed for their future medical careers.

1. Inform a woman, 35, who has been experiencing unexplained fatigue and persistent headaches, that she has been diagnosed with an aggressive form of brain tumour that is inoperable and has an average prognosis around 5 years.
2. Inform the parents of a 16-year old teenage girl who was involved in a severe car accident that due to the multiple traumatic injuries including spinal cord damage, she will be permanently paralysed from the waist down.

Figure 1: Two illustrative instances where doctors face notable challenges in delivering difficult news (generated by OpenAI ChatGPT model (2023), adapted for classroom use)

2) In the second round of activities, the goal is to assist future medical doctors in understanding how patients perceive the reception of bad news. Initially, students are provided with authentic patient statements from which they identify the most prevalent feelings experienced by the patients (see Figure 2). Later, they delve deeper into the patient's perspective by defining the key words that convey the patient's mental state upon receiving a life-changing diagnosis. Finally, students are tasked with generating a set of tips for doctors on how to effectively deliver bad news.

"I was diagnosed on a Friday, and told that on the Monday I would have to deliver our baby, who was exactly 32 weeks. I then needed urgently to begin what would be nearly a year of hardcore treatment: in-patient chemotherapy, dripped through a Hickman line for 72 hours at a time; a stem-cell transplant so brutal it carried a mortality rate of its own and, finally, radiotherapy."

Figure 2: Example of patient reaction to bad news (Guardian Newspaper, 2012, online version)

3) In order to provide students with a better understanding of delivering unwelcome news effectively, the session includes two videos demonstrating incorrect and correct approaches by doctors. These videos, originating from the UK and the USA, provide ample material for analysing intercultural competence. The students, for instance, identify international differences based on their own experiences as patients within the Czech clinical environment. Notably, differences in politeness and the use of inclusive language to reassure patients that they are not alone in their situation are discussed. Subsequently, students are introduced to the SPIKES. By understanding the essential components of the SPIKES protocol and practising the typical doctor phrases for each stage, it is hoped that students will be better prepared to navigate such challenging conversations in their future medical careers.

4) As the culminating step of preparation before the actual role-play, students will once again be confronted with a language activity involving matching the types of questions doctors would ask during different stages of the interview, utilizing the SPIKES protocol. For instance, paired categories and questions could be as follows:

- obtaining the patient's invitation – *"Are there any areas you would rather I did not go into?"*
- addressing the patient's emotions, empathic statement – *"I wish the news were better."*

Another important activity at this stage involves interpreting the patient's informal responses to receiving bad news, especially those expressed through colloquial language. These expressions provide valuable feedback to the doctor about how the patient is coping with the information, e.g. "So, it's curtains for me, is it?", "So, I might pull through?" (examples taken from McCullagh & Wright 2007: 92).

5) The knowledge acquired during the lesson, including the understanding of the SPIKES protocol and various aspects of doctor-patient communication, is put into practice during an approximately 20-minute long doctor-patient role-play session. Students select one of the short scenarios, e.g. Explain to a 48-year-old man that he has a metastatic relapse of their prostate cancer. The patient has been in remission for tree years, and now the cancer has resurfaced. As outlined above, the focus lies on employing empathetic, informative, and appropriately timed language, fostering a collaborative approach in the consultation, with a view towards potential future perspectives.

6) Students engage in peer-to-peer feedback and self-reflection. The value of feedback in healthcare education, particularly for medics and nurses, has been established in numerous studies examining this effective tool for learning

(Cushing et al. 2011, Solheim et al. 2017, Raut & Gupta 2019). However, some studies have pointed out the difficulty some students face in adopting peer feedback (Van Blankenstein et al. 2021). It is worth noting that the process of reflection is part of the ongoing professional development following graduation for clinicians (Stanley et al. 2018), as well as teachers at medical faculties (Ruesseler et al. 2014, Pannekoeke et al. 2023). While the official SPIKES protocol (Baile et al. 2000) does not explicitly endorse peer-to-peer feedback (in ESP role-plays, this would entail feedback from the patient to the doctor) or self-reflection (performed by the doctor for their own benefit without the need to share the findings with others), in my teaching I incorporate both activities with the ultimate goal of enhancing proficiency in delivering difficult news to patients. Moreover, this aligns with the medical simulation-based debriefing approach, which seeks to assess the event in hindsight and extract valuable lessons from it.

The patient questionnaire (Figure 3) was created by teachers at the author's department, drawing inspiration from the SPIKES model. This questionnaire serves as a basis for the feedback given by a student playing the patient to the student playing the role of the doctor. Again, the names of the six steps were taken from Baile et al. (2000: 305-6, 308), for their full description refer to the left column of Figure 3. The questions in the doctor self-reflection questionnaire (Figure 4) were taken directly from Gibbs' Reflective Cycle as cited in Reflection Toolkit at the University of Edinburgh website.

SPIKES stages	**Questions created by the team of English teachers at the author's department**
"**SETTING UP** THE INTERVIEW"	– Did the doctor create a positive and friendly impression by smiling and making eye contact? – Did the doctor introduce themselves and clarify their role? – Did the doctor communicate the purpose or agenda of the interview?
"ASSESSING THE PATIENT'S **PERCEPTION**"	– Did the doctor ask you about …? – Was the doctor interested in understanding your perspective on your condition? Did the doctor ask you about your worries and concerns?
"OBTAINING THE PATIENT'S **INVITATION**"	– Did the doctor ask if you were prepared to hear about your condition or how much information you wanted to know? Did they respect your preferences?
"GIVING **KNOWLEDGE** AND INFORMATION TO THE PATIENT"	– Was the information clear and accurate? – Did the doctor give unfavourable information in a polite and empathic way? – Did the doctor present treatment options? Did they provide explanations regarding the benefits and potential side effects of each option?

"ADDRESSING THE PATIENT'S **EMOTIONS** WITH EMPATHIC RESPONSES"	– Did the doctor use the appropriate words when delivering adverse information for the patient (e.g. expressions like "I am sorry" or "unfortunately")? – Did the doctor maintain a positive and encouraging attitude?
"**STRATEGY** AND **SUMMARY**"	– Did the doctor check that you understood all the information? – Did the doctor discuss the next steps with you? – Did they provide a summary of the information for you?

Figure 3: The patient questionnaire

Stage	Questions taken from Gibbs' Reflective Cycle
"Description"	– "What happened?" "Who was present?"
"Feelings"	– "What were you feeling during the situation?" – "What were you feeling before and after the situation?"
"Evaluation"	– "What went well?" "What didn't go so well?"
"Analysis"	– "Why did things go well?" "Why didn't it go well?"
"Conclusion"	– "What skills do I need to develop for me to do this role play better?"
"Action plan"	– "If I had to do the role play again, what would I do differently?"

Figure 4: The doctor self-reflection questionnaire

As it was found out during the lesson, students were initially unable to anticipate the depth of the answers which the questions were designed to elicit. For this reason, they were subsequently introduced to examples of self-referential, metacognitive and evaluative language. These examples were generated using the OpenAI ChatGPT model (2023) and adapted by the teachers for classroom use (Figure 5).

Self-referential language
- I noticed that I felt anxious during the interaction with the patient.
- I realized that I struggled to convey empathy effectively.
- I found it challenging to maintain eye contact during the consultation.

Metacognitive language
- I was aware of my tendency to interrupt the patient while they were speaking.
- I thought about the possible reasons for the patient's reluctance to follow the treatment plan.
- I recognized that I need to improve my active listening skills to better understand the patient's concerns.

Evaluative language
- In retrospect, I believe I could have been more compassionate in delivering the diagnosis.
- When reviewing the encounter, I acknowledged my lack of clarity in explaining the treatment options.
- I realized that my communication style might have contributed to the patient's frustration.

Figure 5: Examples of self-referential, metacognitive, and evaluative language presented to students (generated using OpenAI ChatGPT model, 2023).

4.2 Administering an online survey to students

The diverse levels of engagement exhibited by students during the role-plays serve as an initial indicator to the teacher of both how well students accept the activity and consequently of their potential to learn. However, formal feedback in the form of an anonymous online survey tends to be a more objective tool for gaining insights into the perceived usefulness of an activity by students. The survey, titled "Clinical Communication with Patients in English Lessons: Students' Opinions and Attitudes", was conducted in Czech to accommodate students with lower levels of communicative competence in English and avoid any constraints on their participation. It was administered through the MS Forms platform, which is available within the Masaryk University IT package. Conducted in April and May 2023, the survey was voluntary (students did not receive any bonus points for participating) and anonymous. The questionnaire reached all first-year students of general medicine at the Faculty of Medicine, Masaryk University in Brno, including four groups taught by the author and 16

groups taught by other teachers at the department, totalling 403 students. A total of 65 students completed the questionnaire, resulting in a return rate of 16 per cent. I find the return rate to be satisfactory considering the circumstances surrounding its administration. It was voluntary and anonymous, conducted right before a rigorous spring exam period, amidst numerous other surveys that students are required to complete on a semester basis. These include university-wide surveys generated by the university information system, which, although valuable, may not fully meet the particular needs of a specific department. As a result, individual teachers within the author's department conduct their own surveys, allowing them to tailor questionnaire items to better address their unique requirements. The survey conducted for the purposes of this paper was the third one within a semester to enquire about students' assessment of the English course. It featured five closed score-based questions, where one point denoted the most positive response (i.e. "very useful"), and five points represented the most negative answer (i.e. "totally useless"). While each closed question allowed students to verbally specify their responses, this option was utilized less frequently. However, the verbal responses provided offered valuable insights into the mindset of the students, complementing the closed questions answered by all 65 students. The questionnaire addressed various topic areas, including: i) the importance of effective communication in providing quality healthcare services, ii) students' perceived level of preparedness for clinical communication resulting from medical English classes, iii–iv) the degree of difficulty or ease with which students assumed the roles of the patient and the doctor, and v) usefulness of peer feedback.

5 Results

The informal face-to-face survey conducted among the team of five teachers involved in delivering the lesson to 20 study groups confirmed the effectiveness of the lesson plan. The plan demonstrated strengths in the following aspects: i) warm-up discussions addressing the difficulties doctors face when disclosing unfavourable information, ii) use of patient-friendly language focusing on adapting complex medical information, including specialist terminology, for the benefit of the patient, iii) incorporation of phrases used in the individual stages of the SPIKES protocol, iv) practice of informal patient language to enable doctors to evaluate patient responses, v) inclusion of peer feedback and a self-reflective questionnaire. As is customary, plans have been made to further refine the lesson plan for future years. Additionally, and more importantly, as indicated above, student data was assessed. The following text and Figures 6-10 present the student data and its interpretation. The information gained from students plays a

key role in shaping the unit in question and, subsequently, larger portions of the course in the future.

The gathered data indicated that the majority of students acknowledged the significance of effective doctor-patient clinical communication in delivering high-quality healthcare. Specifically, 78 per cent of the participants awarded a score of 1 point, resulting in an overall score of 1.72 (Figure 6). Simultaneously, they also acknowledged that more attention should be devoted to clinical communication within the English course and other courses in the curriculum. This is illustrated by the following student's open statement translated directly into English:

> "I appreciate the time we spent communicating with the patient, but I don't think it's sufficient. I assume that we will address this in other subjects as well. Additionally, each student probably needs to find their own approach to this and not rely solely on simulations in teaching. However, it would be beneficial to incorporate additional patient communication simulations into English lessons."

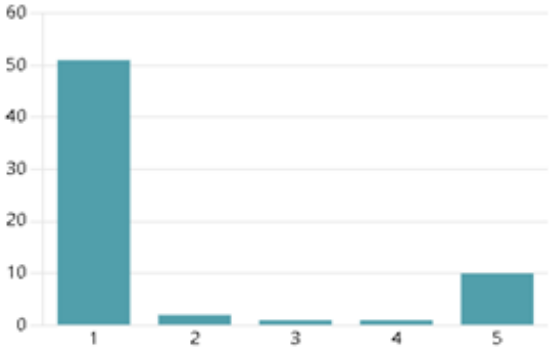

Figure 6: Importance of effective clinical communication as perceived by first-year medical students (1 = very important, 5 = totally unimportant; overall result 1.72)

However, there were slightly less optimistic outcomes when evaluating the impact of medical English classes on achieving or contributing to the achievement of effective clinical communication. The largest section (43%) chose 3 points, resulting in an overall score of 2.91 (Figure 7). This discrepancy may be attributed to the relative independence of medical English classes from the rest of the curriculum and possibly lower trust in English teachers as instructors of clinical communication. While teachers are generally aware of the

ESP boundaries which they adhere to, these speculations are worth considering in future research. This is especially true since students with no previous curricular experience in clinical communication and lacking detailed information about the curriculum in higher years, might be confused about the purpose of the medical English classes, as the following response from a student shows:

> "I DO NOT believe clinical communication should be a part of the English course. I also have reservations about addressing this topic during the first year of general medicine."

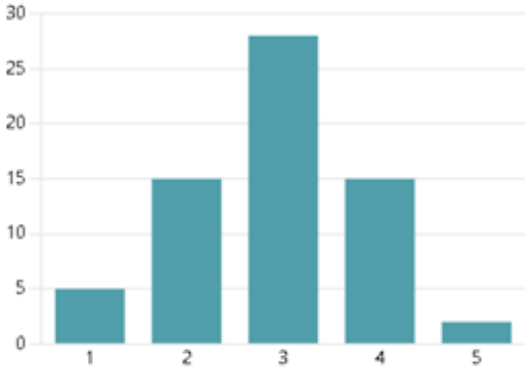

Figure 7: Readiness for real-life clinical communication in English as perceived by first-year medical students after attending medical English classes (1 = well equipped and ready, 5 = not equipped at all; overall result 2.91)

There was a noted disparity in the ease with which students assumed the roles of patients and doctors. Regarding the former, the largest segment of students (43%) chose 2 points, which was followed by 37 per cent choosing 3 points, resulting in an overall score of 2.26 (Figure 8). Concerning the doctor role, the overall result is 3.29 (Figure 9). This is not surprising, considering the students are in their first year, considerably distant from clinical placements which take place in the third year and their future professional practice. Additionally, throughout the questionnaire, students frequently mentioned that they often struggled to find the right phrase in their mother tongue, let alone in English:

> "I haven't been in a similar real-life situation, so it's difficult to fully assume the role of a doctor. Even in regular practice, communicating bad news is so challenging that acquiring average level skills to handle such situations is not easy. This is particularly evident when trying to find suitable expressions in English."

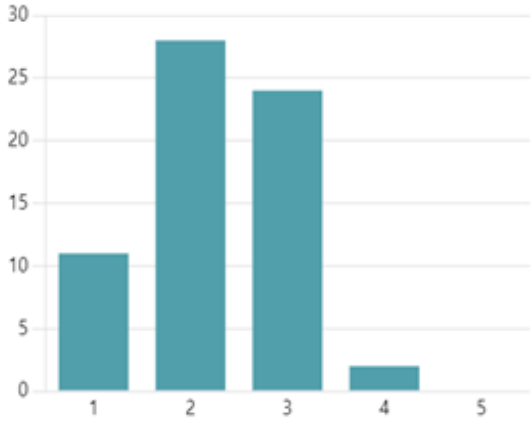

Figure 8: Difficulty of assuming the role of the patient (1 = very easy, 5 = very difficult; overall result 2.26)

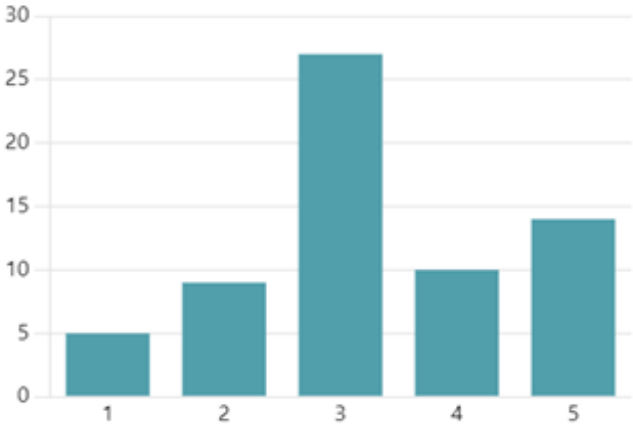

Figure 9: Difficulty of assuming the role of the doctor (1 = very easy, 5 = very difficult; overall result 3.29)

As for the usefulness of peer feedback to the low-fidelity simulation, 29 per cent opted for 3 points, but 18 per cent chose 4 or 5 points, leading to an overall result of 2.43 (Figure 10). This result can be attributed to the relatively limited exposure to the importance of peer-feedback during the classes, which will be

addressed in future years. The written feedback, however, contains positive answers, for example:

> "This was the first semester, and it went well. The low-fidelity simulation here was great. I also believe that feedback is a good teaching method."

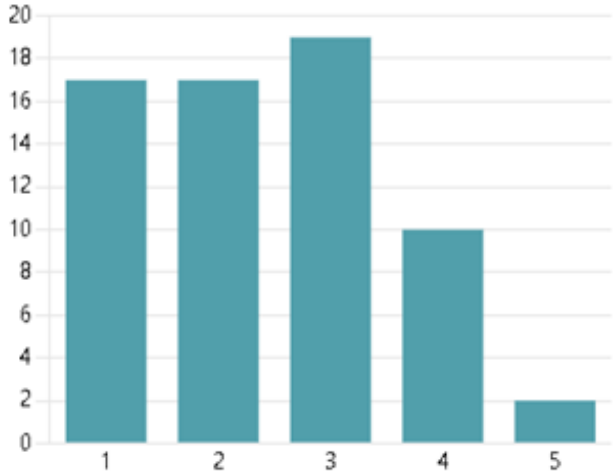

Figure 10: Usefulness of peer feedback (1 = very useful, 5 = totally useless; overall result 2.43)

Potential course adjustments in response to student feedback will include the following features:

1) Incorporating more doctor-patient role-playing opportunities, with a greater focus on the preparatory stage to increase the fidelity of the scenarios. In their comments, some students pointed out that knowing each other within their fixed study groups, in which they undertake the entire studies, might hinder the desired authenticity of the role-play. Knowledge of the role-play partner from formal curricular, as well as informal extracurricular events, may detract from the seriousness of the communication practice, as illustrated by the statement below. Students noted that in the first aid simulation course conducted outside of English classes, their fixed study group was mixed with other groups, making the choice of scenario partner less predictable:

> "The environment of our fixed study group is very informal, which makes it harder to engage in the scenarios. For instance, when teaching first aid, the respective instructors mitigated this by randomly dividing the groups, and the person for whom the simulation was prepared had minimal information about what they were getting into at any given moment."

2) Emphasizing the advantages of self-reflection and feedback will remain a key component. The survey results suggest that it is vital to enhance the practising of self-referential, metacognitive, and evaluative language that is essential for formulating responses to these inquiries.

6 Conclusion

This paper explored and demonstrated the effectiveness of the genre-based approach through the application of an authentic clinical communication tool in the study and teaching of medical English. In a lesson which incorporated the key aspects of the protocol developed by Baile et al. (2000), students were introduced to the complexities of delivering unfavourable news to terminally ill patients. Through a series of activities which culminated in the performance of a role play designed as a low fidelity simulation, students were able to apply their acquired knowledge in practical situations. In alignment with the practice in simulation medicine, students were able to train their ability to critically reflect on their practice, as well as give and receive peer-feedback. The findings from the student online survey provided insights into the perceived usefulness of the activities and the students readiness for real-life clinical communication. While the majority of students recognized the importance of effective clinical communication, there were mixed responses regarding the impact of medical English classes on their preparedness. Similarly, students expressed varying levels of difficulty in assuming the roles of patients and doctors, highlighting the challenges inherently present in pre-clinical medical education. Adjustments to the course based on student feedback will include more opportunities for doctor-patient role-plays, with a focus on enhancing the fidelity of scenarios and emphasizing the value of self-reflection and peer feedback. Integrating authentic clinical communication tools into medical English classes offers a promising approach to enhancing the communicative competence of future healthcare professionals.

Note

[1] Healthcare simulation is a "technique that creates a situation or environment to allow persons to experience a representation of a real health care event for the purpose of practice, learning, evaluation, testing, or to gain understanding of systems or human actions" (Society for Simulation in Healthcare 2020: 21).

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